EXPERIENCING PRACTICE:

AN EXPLORATION OF THE CONSTRUCTED MEANING OF NURSING IN THE COMMUNITY

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ABSTRACT : *Experiencing practice*: *an exploration of the constructed meaning of nursing in the community*

Recent developments in nurse education, principally that pre-registration programmes should prepare nurses to practice in hospital *and* community settings, afford a 'window of opportunity' to make comparison between nurses educated to practice in the community at both first level and post-registration levels. An ontological perspective provided a framework for exploring 'knowing' nursing in the community context, juxtaposing student and community health nurse accounts of their lived experience.

Four pivotal questions provided the focus for a review of the literature : 'What is there to understand about nursing in the community context?' 'How can education be approached?' 'What is the purpose of practice placements?' 'How can nursing be researched?'

Hermeneutic phenomenology, supported by contructivism, provided a theoretical framework for the research. Gadamer's notions of dialogue and fusion of horizons were particularly influential.

Several strategies were employed to access descriptions of lived experience of nursing in the community: focus groups, observation with concurrent interviewing, practice narrative recordings and practice narrative discussions. As a consequence a number of complementary levels of meaning were accessed and provided large quantities of rich data.

In line with the combination of theoretical perspectives, parallel analysis guided by phenomenology and constructivism took place. Phenomenology to identify the meaning level and constructivism to build understanding.

Five core concepts building the constructed meaning of nursing in the community for the research participants were 'practice agenda', time-scale', 'being alone'

'uncertainty' and 'visibility'. The nature of nursing in the community is seen to pivot on nurse participation in patients' lives.

The research suggested that some dimensions of practice in this context are not well appreciated by students. As a consequence, students can only take limited journeys into the world of community nursing. This raises a number of educational challenges, specifically making invisible aspects of practice more visible and addressing the problem of experience of working alone being at a vicarious level. Education could be enhanced by developing ways and means to articulate and share multiple expressions of the practice experience. Dialoguing between parties appears to be an effective way of accessing the practice world and the specific learning opportunities it provides.

A number of contemporary debates - the focus of nurse education, the role of the nurse teacher, learning and teaching in the practice setting, patient participation in care and the blurring of professional boundaries - may all be informed by the research.

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CHAPTER 1

INTRODUCTION

Introduction

The focus of this research is nursing in the community. Specifically, it explores qualified and senior student nurses' experiences and understanding of practising and learning to practise nursing in the community context. Exposition and comparison of these different dimensions of experience is then utilised to clarify educational need.

'Community' is a term in every day use. Its meaning appears superficially obvious and may commonly be defined as the opposite to an institutional setting. However, the impact, if any, of practising nursing in a community as distinct from an institutional *context* has received limited attention. Drawing on Silverman's (1993) concept of 'contextual sensitivity', this research explores the experience of both practising nursing and learning to practise nursing in the community context. The study is influenced by the philosophy expounded by Eraut (1994):

> "The barriers to practice-centred knowledge creation and development ... are most likely to be overcome if higher education is prepared to extend its role from that of creator and transmitter of generalizable knowledge to that of enhancing the knowledge creation capacities of individual and professional communities." (p57)

The evolution of the research can initially be traced to four issues:

1. *The movement of health and social care from institutions to the community setting*

2. *Changes in nurse education*

3. *The growing body of discussion relating to reconceptualisation of theory and practice and models of professional education*

4. *The growing endorsement of humanistic and naturalistic perspectives in nursing and education research.*

Movement of health and social care

In 1974 the World Health Organisation encouraged a change in health care focus from:

> "...the narrow focus of care for the ill few in the hospital to the wider vision of the many cared for in their own environment..."
> (Husband 1991:25)

The agenda for health care detailed in recent policy statements (NHS & Community Care Act 1990, Primary Care: Delivering the Future 1996, New NHS, Modern and Dependable 1997) has a very strong community and primary health care focus and has the potential to affect many branches of nursing. Employment and educational implications are inherent in this movement of health care.

The number and type of workers in the community health care setting is being scrutinised in response to these increased and changing demands. Current and traditional nursing roles are being challenged. New roles are developing such as nurse practitioners, and community staff nurses. According to the Heathrow debate (1993):

> "Nurses will be asked what it is that they do that is special, that others cannot do."

In her study of district nursing McIntosh (1996) identified that anyone unfamiliar with the intricacies of the community nurses' practice may only see a set of tasks being performed. They may be blind to the professional artistry within the role. The outcome may be that inappropriate skill mix decisions could result. It would be difficult to criticise budget holders for veering to such decisions if they are not provided with information over and above the task description information

currently available. McIntosh's concern at this situation is evident in her comment:

> "...attempts to uncover professional artistry in district nursing must be vigorously pursued." (p323)

Nursing is being invited to define itself, to declare its contribution to health care.

The question is more complex than "what do nurses do?" - an activity analysis approach. One dimension of the question being posed relates to what do different grades+ and levels+ i.e. first level, specialist practitioner, advanced practitioner, do. These levels of nursing practice are currently being debated by the United Kingdom Central Council for Nursing (UKCC) and the qualitative difference between the different levels has yet to be clearly defined. In order to answer these questions nursing has to move from a descriptive/task analysis of practice to explore the detail of the experience of practice. This research will contribute to the debate on these issues in relation to community nursing.

Changes in nurse education

The increasing policy emphasis on health and community care has educational ramifications. For example, in 1985 the World Health Organisation recommended a reoriented nurse education curriculum with an increased emphasis on primary health care and community health. Changes have consequently occurred in nurse education at an international level e.g. USA (Kenyon 1990), Canada (Bramadat, Chalmers and Andrusyszyn 1996), Sweden (Persson & Myrin 1997).

+ see glossary

In the UK one of the key changes introduced with the UKCC paper, 'A New Preparation for Practice' (1986), was that pre-registration programmes should prepare nurses to practice in hospital *and* community settings. Historically, first level preparation has prepared students to function as a staff nurse+ in a hospital setting. Previous and current approaches to education are presented in more detail in Figures 1 and 2.

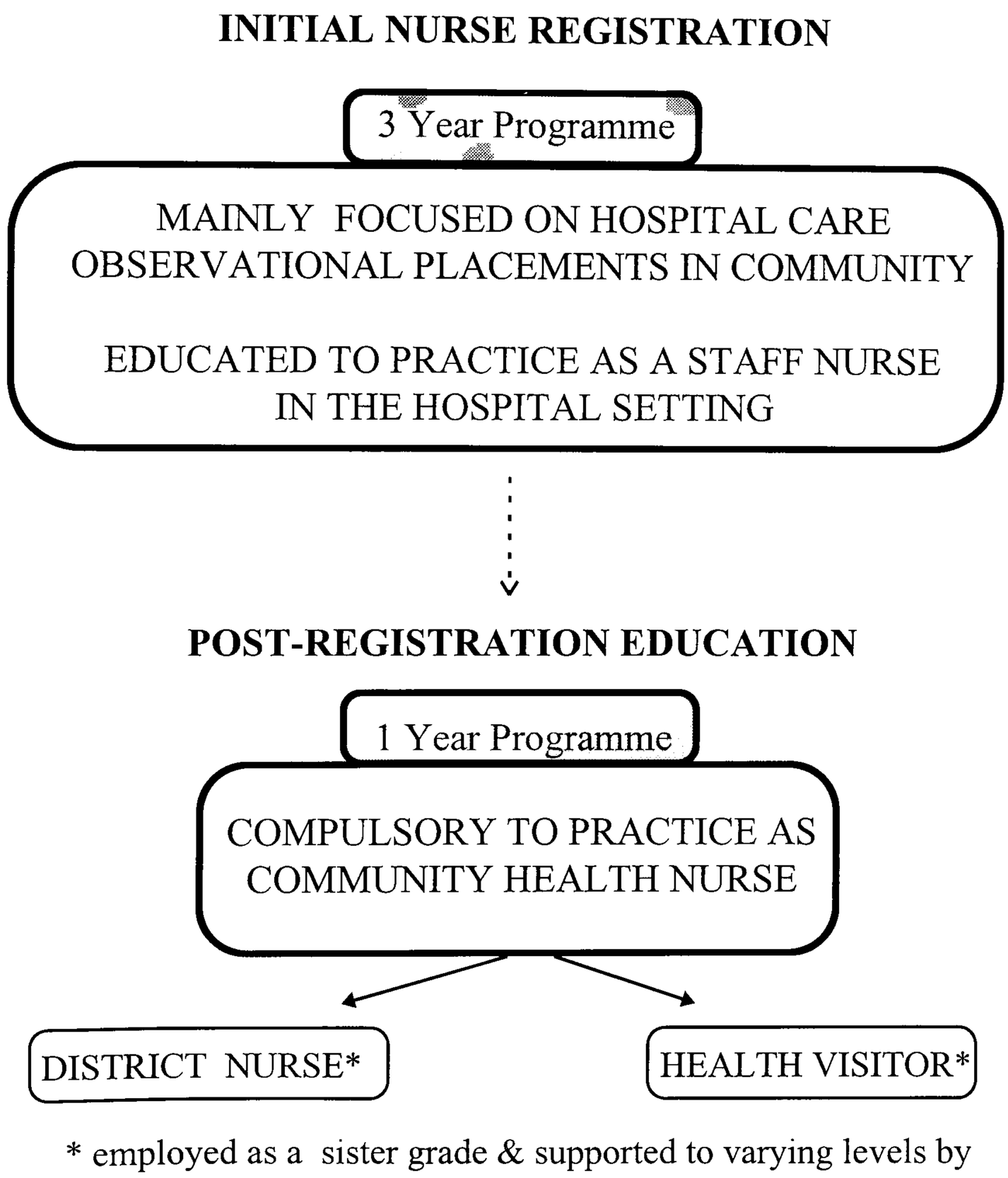

Figure 1 Model of nurse education prior to 'A New Preparation for Practice'

A NEW PREPARATION FOR PRACTICE
(PROJECT 2000)

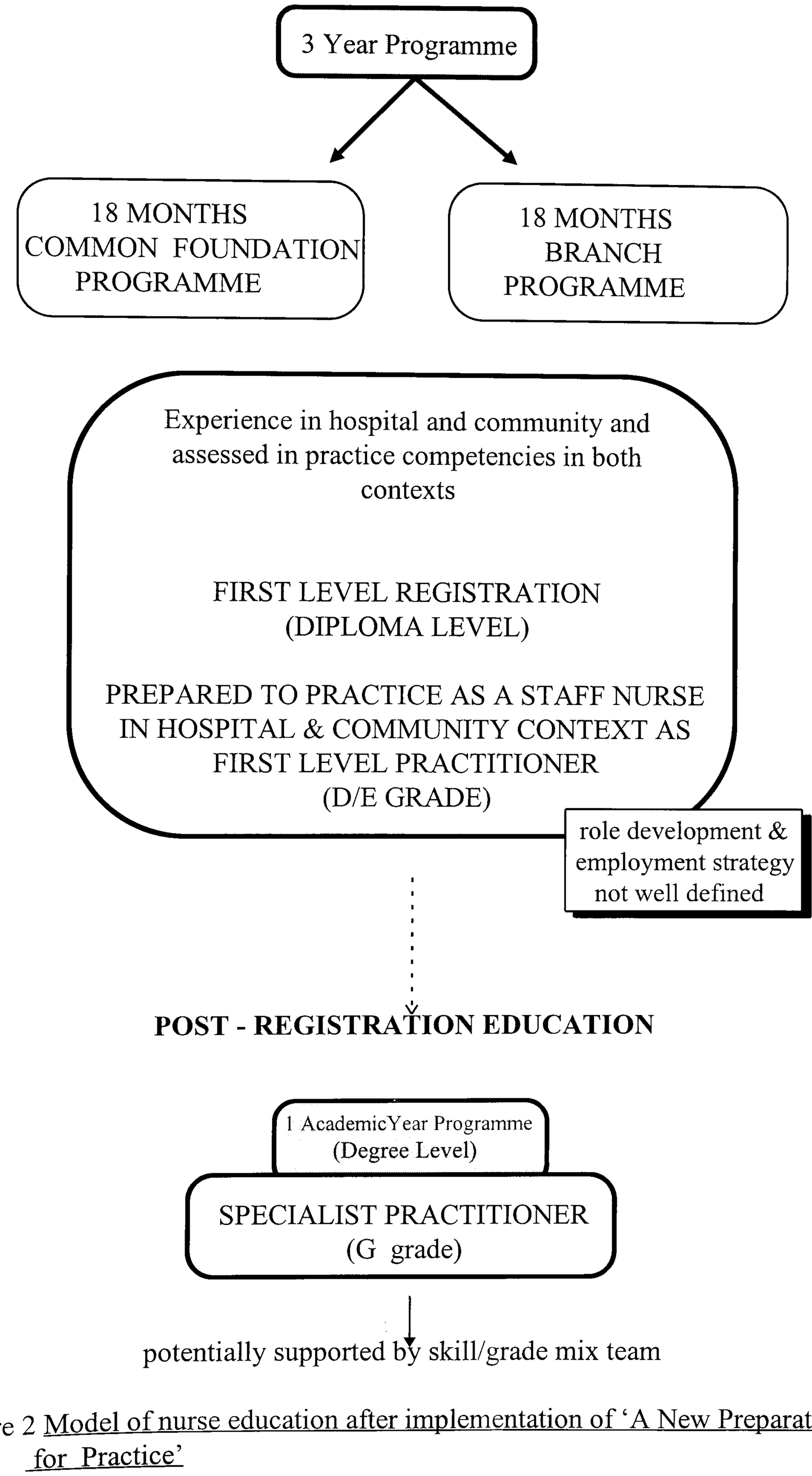

Figure 2 Model of nurse education after implementation of 'A New Preparation for Practice'

So, for the first time, we now have an initial education programme that is intended to prepare nurses on qualifying to function in both hospital and community contexts.

Kenyon et al (1990) commenting on the impact of a similar hospital to community shift in the USA criticise :

> "...the false impression that nursing in the home is nothing more than a change in practice site, requiring the same skills and skill levels as the acute-care arena." (p33)

They stress that patients require acute care *and* community health nursing skills and identify several differences between hospital and community care e.g. in case finding, value orientations, collaboration and assessment. However, the key message to be drawn from their research is that there is limited clarity about what differentiates practising nursing in hospital and community other than the change in geographical location.

Bramadat, Chalmers and Andrusszyn (1996) identify that few research studies have examined the educational preparation for community practice. In view of their assertion that "...community places unique demands on nurses" this would appear to be a major deficit. They report a study focusing on educational preparation in which they collected perceptions of nurses, administrators and educators and identified issues around:

- conceptualisation of community health practice (epidemiological issues, working with not for clients),
- process skill (assessment, problem solving)
- content (client groups, family therapy)
- personal qualities (maturity, independent decision making, 'guest in the house')
- practice experience (adequacy)

Bramadat, Chalmers and Andrusszyn (1996) focused on perceptions, not manifestation of these issues in practice. This current research study utilises lived experience rather than perceptions as a framework for exploration.

Oilier (1982) draws attention to the often neglected distinction between labelling and description, with nursing classified by speciality, but with limited description of the detail. This is not restricted to community nursing. There is a dearth of formal knowledge about the substance of nursing practice, what Meleis (1991) calls the 'business of nursing'.The absence of such information becomes glaring at times of change and scrutiny. This research therefore has the aim of achieving description rather than labelling.

The early research work in response to the introduction of *'A New Preparation for Practice'* (UKCC 1986) has been at a rather pragmatic level. As most of it was commissioned by the nursing regulatory bodies, the adoption of this perspective is perhaps understandable. For example, research by Orr and Hallett (1993) and Hallett et al (1995) identifies some of the national concerns about the new developments i.e. that there is a degree of uncertainty as to the aims of the students' community experiences, what students need to experience and what they need to learn. A crucial issue for exploration is clarification of what should be the education outcomes of clinical experiences in the community. What is there to learn about practising in the community context? Hallett, Williams and Butterworth (1996) highlight that when students were asked about their learning experience during a community placement, towards

the top of their list was dressing techniques. They also identified that communication skills were valued and well used in the community context. The impact of context is not explicit in these comments. Explicating the detail of practice rather than a task description is a challenge for nursing generally. Kitson (1993) has highlighted the problems of nursing interventions being seen as a set of actions, thereby potentially restricting our understanding of the totality of nursing practice. Hallett's and Kitson's comments raise concern about surface and deeper levels of learning which could potentially take place in relation to nursing practice.

Further consideration of the impact of the increasing focus on 'community' in nurse education highlights education provider issues. For example, one of the consequences of the drive to increase the 'community' component of pre-registration programmes has been the recruitment of educationalists with a clinical background in community nursing: the purpose being to meet the increased need to teach 'community'. This seems to acknowledge that practising nursing in the community context is different to other aspects of nursing and demands different knowledge and skills. However, there is little research exploring what these differences might be.

Another issue inherent in this trend in educator recruitment is also worthy of comment. It appears that there is an underlying assumption that possession of subject or clinical knowledge will allow that person to teach that subject.

However, Schon (1983) has acknowledged that such 'knowing-in-action' does not automatically mean that this knowledge can be utilised in the education context. The role of the nurse teacher is under intense scrutiny, exemplified by the report '*Teaching in a Different World'* (RCN 1993) which is already being reviewed. Clarification of education needs may also provide useful directives for the role of educator, specifically the value or contribution of an educator who is also a nurse.

Reconceptualisation of theory and practice

Changes in health and social care policy, and the consequent questions about practising and learning to practise community nursing, were occurring at the same time as, and were further stimulated by, the growing body of discussion relating to reconceptualisation of theory and practice (Benner 1984, Schon 1987), models of professional education (Bines and Watson 1992) and research into learning in practice (Fish, Twinn and Purr 1989,1991). There is also considerable discussion about the articulation of theory driving practice professions such as nursing. Theory development, according to Sims (1991:53) involves:

> "...searching for answers which clarify the nature of nursing..."

The call for articulation of theory is becoming louder and more urgent as Timpson (1996) says:

> "...theory development within nursing constitutes a vital component in the survival of and evolution or convolution, of nursing...." (p1030)

Several professions are pursuing this aim, for example in the clinical method of medicine (Gale & Marsden 1983), the practice theory of social work (Bailey & Lee 1982), and Benner's (1984) description of the continuum of novice to expert practice in nursing . In relation to social work, England (1986) endorses the need to clarify the 'character' of social work and he also acknowledges the complexity of such a task.

The developing field of knowledge elicitation research "...expressly devoted to developing methods of characterising what experts know" (Eraut 1994:15) makes an important contribution to this task and to this current research study. It builds on professional expertise work (Schon 1983, 1987) and knowledge embedded in practice. The knowledge creation or development capacities of professionals are recognised as being underdeveloped. The under utilised activity of reflection is highlighted and regretted:

> "...there is no tradition of engaging in such behaviour in most professional work contexts ; and knowledge development receives little attention in an action-oriented environment." (Eraut 1994: 56)

Although focusing on student teachers, these comments have relevance for the world of nurse education. Eraut advocates learner and teacher sharing discussions on theory use in practice. The learners' capacity to theorise about their practice should be nurtured. The concept is endorsed by Eisner (1991) who uses the term 'educational connoisseurship', the ability to perceive the detail of the experience. He refers to the visual arts where " to know depends upon the ability to see, not merely to look." (p1). There is growing acceptance that experience may result in

learning (Schon 1983,1987,1991), but to achieve maximum effectiveness, students have to be facilitated to 'see'.

Nursing and education research paradigms

The options available to researchers in the practice professions have recently developed to endorse the naturalistic paradigm. Eisner (1991) in relation to education and Watson (1988) and Benner (1984,1994a,) in relation to nursing are three prominent examples of this trend.

Eisner (1991) advocates the use of qualitative, naturalistic approaches to educational inquiry that will allow a wider understanding of 'what it means to know'. Watson (1988:8) questions whether nurses should continue to follow a 'science' approach to research or take another approach to reality by developing a "new lens for seeing nursing". Benner (1984,1994a,) has made a very significant contribution to understanding nursing and how researching nursing may be approached. Her work, which recognises the centrality of practice and experiential learning continues to receive considerable attention in the nurse education world.

Nursing is embracing research paradigms that look beyond a descriptive level, but aim to access the essence of nursing and the experience of nurses and patients. For example, Taylor (1994) has explored the phenomenon of *ordinariness* in nursing by accessing and interpreting patients and nurses' experiences of nursing. Darbyshire (1994a) sought to explore the experience of

living-in paediatric wards from parent and nurses' experiences of this phenomenon.

It has not been possible to identify any examples of this perspective being adopted to study the experience of nursing from qualified practitioner and student perspectives. It would appear to be highly appropriate to utilise such an approach at this time of change in nursing practice and education. Recent developments in nurse education allow comparisons to be made between nurses educated to practise in the community at both first level and post-registration level. This provides a 'window of opportunity' to better understand professional practice by exploring the experience of nursing from a practitioner and learner perspective.

Research aims

The research explores the constructed meaning of nursing in the community context and aims :

- To access and describe the constructed meaning of community nursing practice in order to enhance the way in which practising nursing in the community context is understood

- To add to knowledge of the notion of 'community' as a context for nursing practice

Overview of research

Phenomenological philosophy and constructivist theory have been very influential in the development and implementation of this research. For clarity of presentation, a traditional format is adopted in this thesis. However, in keeping

with the philosophical basis of the research, the style of thesis presentation includes an element of constructed 'lived-experience', sharing the interpretation of the research question and outcome as it progressed. The thesis is presented in the following sections:

◊ A literature discussion is presented in Chapter 2 which draws on the disciplines of nursing, education and research. The range of issues is wide and complex. Four pivotal questions about nursing and the community as a context for practising and learning to practise nursing were formulated; 'W*hat is there to understand about nursing ?' 'How can education be approached?' 'What is the purpose of practice placements?' 'How can nursing be researched?'* These questions provided the focus for the literature review.

◊ Chapter 3 presents a two part discussion of the theoretical paradigm guiding the research. First, issues relating to the general theoretical framework are presented together with a review and analysis of a range of perspectives within the interpretive paradigm. Hermeneutic phenomenology is identified as the framework guiding the research. Secondly, the theoretical decisions made in this study are discussed with respect to their chronology and dependence on the approaches underpinning the research process itself.

◊ The research strategy development and implementation is reported in Chapter 4. The identification of the research sample from within two community trusts is outlined. The research design consisted of multiple

phases of data collection; focus groups, observation with concurrent interviewing, practice narrative recordings and practice narrative discussions.

◊ Interpretation style and analysis of data is discussed in Chapter 5. The analysis is guided by the interpretive paradigm, specifically hermeneutics. Although analysis was a dynamic and iterative process, it is presented chronologically by data collection phase to enhance clarity and auditability. Core concepts that appear to provide a framework for understanding the phenomenon of community as a context for practising and learning to practise nursing are identified.

◊ Chapter 6 accesses another interpretive level that further unravels the meaning of practice as expressed by this group of students and community nurses. Five explanatory concepts are identified; *practice agenda, time, being alone, uncertainty, visibility.* Related literature is incorporated into the discussion to explore and develop understanding of these concepts.

◊ In Chapter 7 the phenomenon of nursing in the community context is discussed. Participation, patient participation in their care and nurse participation in patients' lives are identified as pivotal issues. The questions posed in the literature review, *'what is there to understand about nursing* ***in the community context'****, 'how can education be approached', 'what is the purpose of practice placements', 'how can nursing be researched',* are revisited drawing on the meaning derived from this research.

◊ Chapter 8 provides a summary and conclusion detailing the process and outcome of the research. The potential contribution of hermeneutic phenomenology and constructivism to researching nursing and learning to nurse is discussed. The contribution of the research to understanding of 'community nursing' is identified. Suggestions are made for enhancing the education experience by developing ways and means to articulate and share multiple expressions of practice experience. Finally, a number of contemporary debates are discussed drawing on the understanding developed from this research.

Summary

Changes in health care policy and approaches to professional education constitute a major shift in nurse education and employment. This represents a critical juncture in the history of community nursing and provides the main impetus for this research study.

At a time when the nature of nursing knowledge is being addressed in new ways, this research is about how *'community'* as a *context of practice* can be understood through the experiences of practitioners and learners, guided predominately by an ontological perspective. The purpose of exposition and articulation of the experience of practice in this research is the facilitation and clarification of educational need.

CHAPTER 2

OVERVIEW OF THE LITERATURE

Introduction

The literature informing and focusing this research has been drawn from the disciplines of nursing, education and social research. The range of issues is wide and complex. This is managed by formulating pivotal questions about nursing and the community as a context of practising and learning to practise nursing (Figure 3). Each of these questions then provided a focus for the literature review.

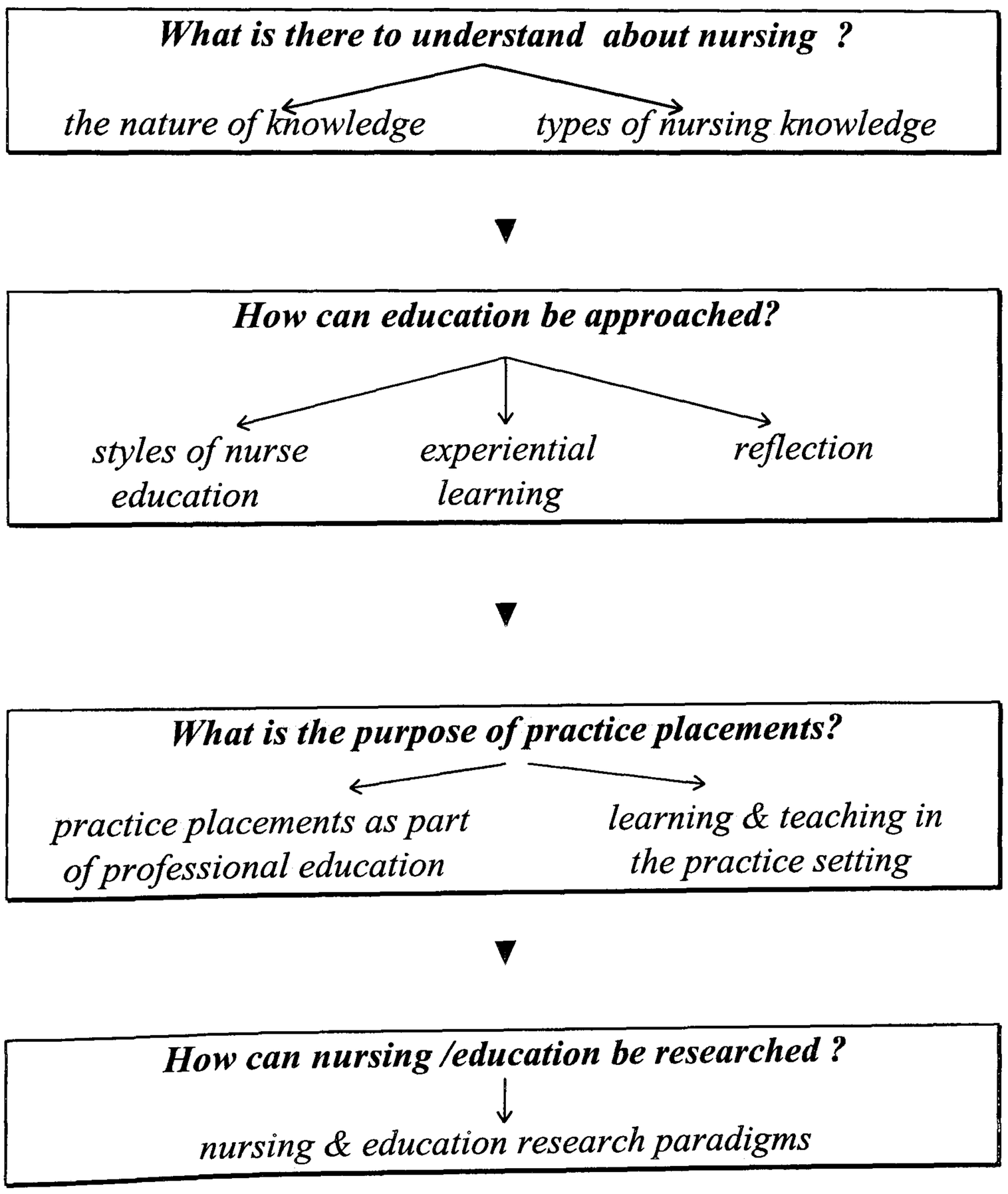

Figure 3 Overview of the literature

Although this research does not specifically address theory development, understanding how nursing is currently perceived and taught is important to clarifying the manner in which this research has been conceived and designed. It is important to reiterate that the rationale for this research is developing our ability to elucidate the experience of community nursing practice by students and community nurses with the intention of addressing educational needs of community practitioners.

This chapter both reviews the literature informing the research and highlights the types of research question which have been addressed in nursing and the research frameworks which have been favoured over time.

WHAT IS THERE TO UNDERSTAND ?

Although the aim of this research is to develop understanding of nursing in the community context, the more generic question *'what is there to understand about nursing'* is posed here. In order to answer this question the different paradigms competing to explain nursing and nursing knowledge must be explored. According to Rolfe (1998):

> The dominant paradigm of a discipline is...extremely powerful in determining the nature of what counts as knowledge, how it is generated and how it is disseminated, as well as the underlying values and beliefs of that discipline." (p1)

As is apparent in the above quotation, definitions of knowledge and approaches to education are closely linked. This section explores some of the different interpretations of what counts as nursing knowledge and how it is developed. A detailed discussion of approaches to education is presented in the next section of this chapter, however there is inevitably some overlap.

Nursing has historically embraced two paradigms, the practice-based paradigm and the technocratic paradigm. Rolfe (1998) argues that until the 1970s nursing followed the practice based paradigm, swinging to the technocratic approach in the 1980s. He now identifies a 'shift back' to the practice paradigm. His term 'shift back' suggests reverting to what we did before, but this is not a complete explanation of current trends. It is true that the practice paradigm is receiving more attention, but the focus takes a different dimension to the last practice era. Nursing knowledge developed from and for practice is now being recognised and

developed. Bines and Watsons' (1992) distinction of pre-technocratic, technocratic and post-technocratic approaches provides a better description of the changes. It more accurately reflects the growing acceptance of science and artistry.

In their discussion on the foundation for nursing as a science Fjelland and Gjengedal (1994) draw on the 1386 debate about the design and construction of Milan cathedral to demonstrate the value of knowledge derived from science and from art. This was apparently the first such structure to deviate from the traditional Gothic style. The rules of design and construction currently in use would not apply to the new shape of building desired. Expert, scientific opinion was sought from other parts of the world. Two arguments were put forward to handle the project:

> "architects of Milano were not competent to carry out the project because they lacked the required theoretical knowledge, and concluded , 'Ars sine scientia nihil est' (Art without science is worthless). But the architects and engineers of Milano used the opposite argument in their defence: 'Scientia sine arte nihil est' (Science without art is worthless). They prevailed, and the cathedral of Milano was constructed according to their instruction." (p4)

The building still stands and the account emphasises the value of both art and science.

Similarly, in their critique of different models of practice education Bines and Watson (1992) stress that it is not a case of rejecting one source of knowledge in

favour of another but finding the appropriate combination:

> "...the role of technical knowledge and understanding is certainly not dismissed - just given a more limited place, with artistry mediating, rather than being excluded, by applied science and technique." (p18)

The discussion in this section *'what is there to understand about nursing'* does not aim to defend one type of knowledge against another. Rather it aims to explore the range of knowledge that may inform and enhance our understanding of practice from both epistemological and ontological perspectives. It must be acknowledged however, that the former still predominates in the literature.

The nature of knowledge

Eraut (1994) suggests that people tend to use the term knowledge only in relation to codified text book knowledge. According to Tolley (1995) this may be explained by nursings' historical struggle for academic credibility and consequent reliance on logical empiricism. This perspective has led to a limited ability or awareness of the nature and extent of other forms of knowledge. The theory implicit in practice is therefore not well established.

Recently there have been a number of attempts to capture the knowledge of practice and varying perspectives have been offered. Eisner's (1991) work *'The Enlightened Eye'* advocates a broadening of our conception of knowledge with the aid of naturalistic research approaches. Benner (1984) argues against the objective/subjective distinction of knowledge and instead suggests a distinction

between knowledge embedded within a particular context and knowledge that is formal and abstract. This ontological shift in education and education research is very significant for this research study and will be developed further in the next chapter which focuses on the theoretical framework of the research.

Bailey & Lee (1982), with reference to social work, identify two types of theory. One type can be thought of as theory/ies of practice that consist of direct borrowings from related disciplines and the second as a less-defined category of practice theory derived from exposure to the practice situation. This is presented diagramatically in Figure 4.

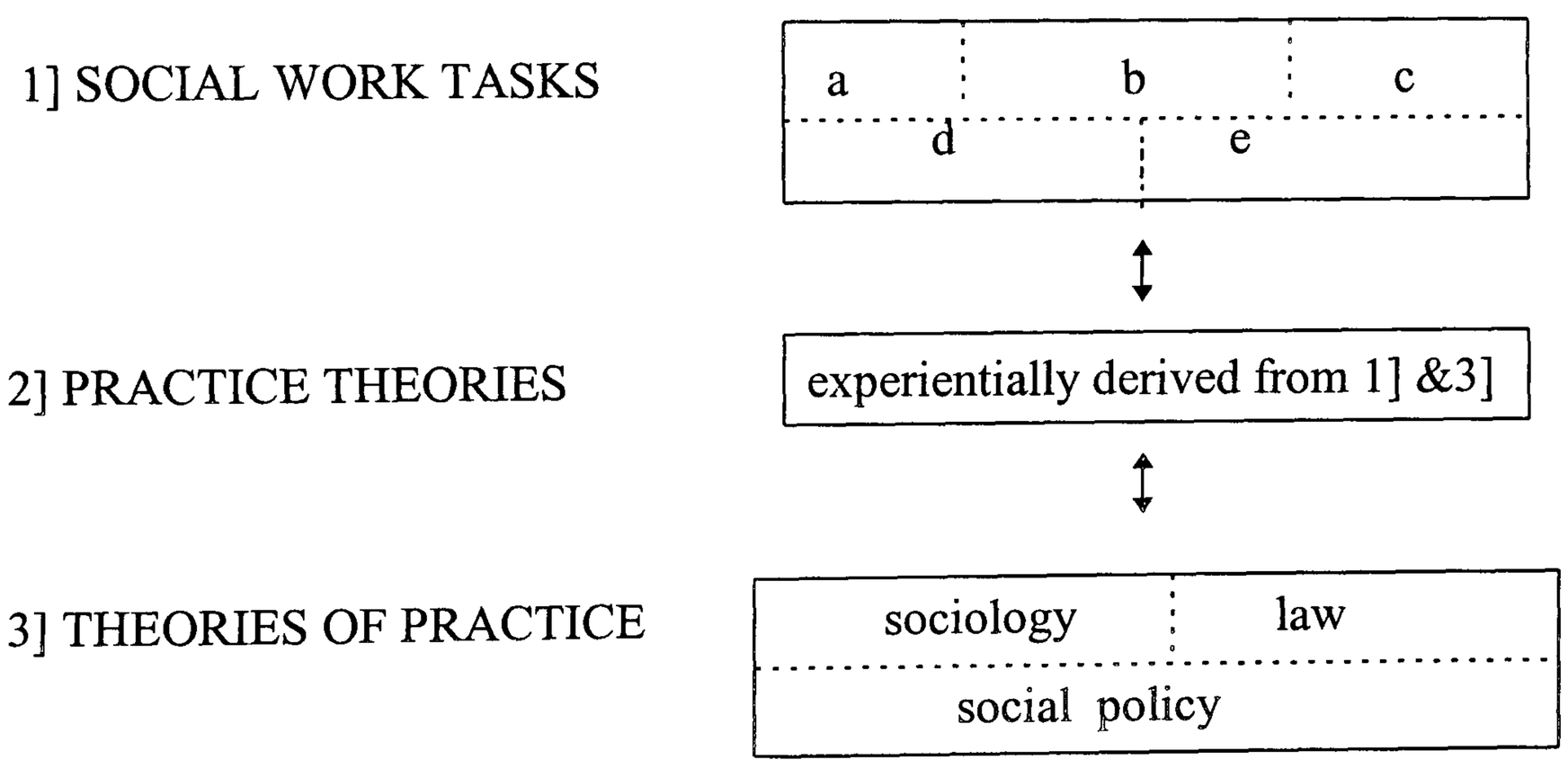

Figure 4 Types of theory in social work practice (modified after Bailey & Lee 1982)

The validity of this scenario for other practice professions must be considered. As social work and nursing both draw on a range of theories of practice and adopt practice placements as an important part of their education programme, this research assumes that these categories of theory types would also apply to nursing. A significant distinction does exist between social work and nursing in relation to 'tasks'. Nursing tasks may have a much more practical or technical orientation. However these tasks only tell part of the nursing practice story. In relation to student learning this could increase the complexity for student nurses in that they may have to look beyond the tasks to reveal the complete practice picture. This research study is therefore focused at the level 2 area identified in Figure 4, the theory or meaning that practitioners and students develop through exposure to the experience of community nursing. This is in line with the movement in nursing to develop its own theories rather than depend on theories borrowed from other disciplines (Tolley 1995).

A similar type of classification is offered by Argyris and Schon (1977) who identify two distinctions. One type is referred to as 'espoused theories', those theories professionals often refer to when describing or justifying their practice. The other type is 'theories-in-use', the operational theories which practitioners actually use, and which may not be easily articulated by practitioners themselves or to others.

Polanyi (1967) suggests that we know more than we can tell, not always because the knowledge is inaccessible, but because we do not have adequate means of

expressing ourselves. He uses the example of someone not being able to exactly describe the distinguishing features of a face until the tool of a police photo-fit picture allowed or prompted them to express the knowledge they held. This has implications for the interpretivist view of knowing. According to Eisner (1991):

> "What we look for, as well as what we see and say, is influenced by the tools we know how to use and believe to be appropriate." (p4)

This endorses the constructivist view of knowledge and learning. Learners enter into a construction process and the facilitation of that process will determine the learning outcome. There could be considerable qualitative differences. Eisner quotes Picasso:

> "A painter takes the sun and makes it into a yellow spot. An artist takes a yellow spot and makes it into a sun." (p9)

Bines and Watson (1992) highlight that one of the challenges of the post-technocratic approach to education is the need to develop understanding of professional practice and competence. In reviewing approaches to researching social work practice White (1997) identifies that a reliance on the quantitative approach has resulted in a limited knowledge of the 'sense making' activities of practice. In a similar vein with respect to teachers, Calderhead (1988) suggests that a pre-requisite to improving teacher education is enhanced understanding of teacher knowledge. The same comments might be made in relation to nurse education.

There is a growing literature on knowledge articulation and reflection (Kolb 1984, Boud, Keogh and Walker 1989, Schon 1987,1991 Eraut 1994). Nurse researchers, notably Benner (1984), Benner Tanner and Chesla (1996) have recently started to address some of the knowledge deficits in nursing. However, Eraut (1994) offers some words of caution to those pursuing the articulation of knowledge embedded in practice:

> "Critics may illuminate the knowledge embedded in a piece of music, a painting or a dance but they cannot fully represent it in words." (p15)

The process of practice may contain too much information and information digesting to capture and describe it in a propositional form. Knowledge articulation is not necessarily an automatic progression from tacit knowledge awareness. The developing field of knowledge elicitation research has established that "people do not know what they know." (Eraut 1994:15). This statement obviously spells caution for this research. However, the rationale for pursing the articulation of the experience of practice lies in the work of a number of researchers/authors who have achieved similar aims i.e. Benner (1984), Mcleod (1990), Schon (1991) Darbyshire (1994a).

Despite their generally tacit nature, Schon (1987) contends that what he calls 'theories-in-use' can be reconstructed. He has used reflection as a means of accessing the theory of practice in a range of occupations, i.e., teaching, town planning, occupational therapy. Boud, Keogh & Walker (1989) define

reflection as:

> "...those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new understandings and appreciations." (p19)

Reflection, as an approach to education will be discussed in detail later in this chapter under the heading of *'how can education be approached?'*

Types of nursing knowledge

There has been a definite objective/subjective distinction in nursing knowledge classifications with science being more highly valued than art. However, according to Carr (1996) nursing has recently experienced:

> "...a shift from the positivist paradigm of rationality, objectivity and truth to the interpretative paradigm which seeks to understand" (p289)

The knowledge distinctions reported by Carper (1978) approximately 20 years ago exemplifies the approach to science and artistry at that time. She identified four types of nursing knowledge that sought to balance knowledge from the sciences and arts:

1. Empirical knowledge: The recent upsurge in evidence-based care obviously adds weight to empirics as a component of professional knowledge. However, Johns (1996) suggests that empirics should not be seen as the driving force of nursing knowledge, but rather it should be seen as "informing aesthetics".
2. Aesthetic knowledge: This type of knowledge acknowledges that nursing practice and care is not a standard commodity, but something that is negotiated to respond to differing clinical presentations. Carper identifies that

limited effort has been devoted to making this aspect of nursing knowledge explicit.

3. Personal or self knowledge: This aspect of knowing relates to the notion of involvement, at whatever level, that is inherent in a caring relationship. It relates to seeing the patient as a fellow human being and understanding of their situation from this perspective. It also involves the therapeutic use of self.
4. Ethical knowledge: Referring to the moral component of nursing, the choices that the nurse may be faced with which rely on moral principles for resolution.

The relevance of these different dimensions of knowledge for community nursing practice will be addressed in the 'Discussion and Integration' chapter of this thesis.

Rather than dissecting nursing knowledge into different dimensions, Jacobs-Kramer and Chinn (1988) advocate an integrative approach. Drawing on Munhall's work they suggest:

> "An examination of the art-act that integrates all knowledge patterns as expressed in practice provides a comprehensive, context-sensitive means for enfolding multiple knowledge patterns. This shift towards integration of all knowledge patterns will move nursing away from a quest for structural truth and toward a search for dynamic meaning." (p138)

Important questions arising from these debates are: 'Is knowledge to be located outside of nursing practice and then applied to practice'? or 'Is knowledge

developed from practice'? The view that knowledge is applied in practice is being questioned in a range of professions. Indeed Bines and Watson (1992) state that:

> "Most professional activity is based not on a two-step application of knowledge to practice but on an integrated knowing-in-action, much of which is spontaneous and tacit." (p13)

The theory/practice gap in nursing has been acknowledged for some time. A number of explanations for its existence have been offered. For example, Carr (1996) identifies a division between:

> "...what is experienced in reality and what is taught in the classroom...." (p290)

Rafferty, Allcock and Lathlean (1996) suggest that at the core of the concept of the theory-practice gap is the erroneous assumption that theory and practice can be separated. In their view "Theory and practice do not ...exist in splendid isolation" (p686). A recurring argument focuses on the inadequacy of science or borrowed theories to account for actual nursing practice. Rolfe (1998) refers to Maxwell (1984) to further explain what is required:

> "In order to practice effectively and ethically, nurses must look beyond scientific knowledge and theory, and it is therefore necessary to explore the wider epistemology of nursing. What is required is a form of knowledge that will 'articulate ...the basic problems we wish to solve, and...propose and critically assess possible solutions." (p25)

Various attempts have been made to try to address the problem. One strategy is to take practice, rather than theory as the focus of curricula development. Reed and Procter (1993) identify one movement which they title 'radical academia' aiming to uncover nursing knowledge from clinical practice. Uncovering

knowledge from practice and focusing curricula development on practice appear to be inextricably linked. An important question to consider is: who should be uncovering the practice knowledge? Tolley (1995) suggests that if academics take the lead role the end result may be technical rationality by default; theory development by theorists to be made available to practitioners. Although acknowledging that clinicians are immersed in the practice experience, Tolley questions whether they would wish to take on the task of practice knowledge development. It is possible to identify a number of barriers to them taking on the role. They may be immersed in practice but this does not guarantee an ability to articulate their practice theory. Their primary role is provision of care so time restrictions would be a major barrier. Practitioners have chosen to practice nursing, they have not taken the option of teaching or researching nursing, so their inclination may also be questionable. However, it could be argued that it is inappropriate to debate whether it should be academics or practitioners who develop practice knowledge. Is this either or option not merely perpetuating the potential for a theory/practice gap? The more appropriate option would be a union between the two parties, each contributing their specific skills. With this more symbiotic model of theory and practice in mind, this research adopts a collaborative researcher/participant philosophy.

A considerable amount of 'know-how' knowledge of practice professions is at an implicit level, which perhaps has had some influence on the status it has historically been afforded. Schon (1987) suggests that there should be a greater degree of integration between knowing and doing, believing in the potential to

articulate theories-in-use. Indeed he advocates that in order to improve practice, the knowledge implicit in knowing-in-practice should be made explicit

Rolfe (1996) refers to the traditional definitions of nursing which have been concerned with physical care-giving and technical procedures. This has been the dominant paradigm for generating nursing knowledge and he suggests a reformulated approach to generating nursing theory and knowledge is needed. In his work *'The Deconstruction of Nursing'*, Ramprogus (1995) cites Hardy's (1988) reference to the proliferation of nursing theorists in the 1970s and 1980s:

> "...there was too much uncritical acceptance of the nursing theorists' work and that has been to the detriment of serious exploration and development of nursing knowledge emerging from practice." (p50)

Meerabeau (1992) summarises the current situation declaring that:

> "The consensus is that practitioners' knowledge is a largely untapped resource, and that research has been too narrowly defined by the academic community, who question why practitioners do not use research based knowledge. If a broader framework is used, it is seen that practitioners also create new knowledge, but it is often not codified or published, nor is reflection and discussion often possible in the work environment." (p110)

As stated earlier, Benner (1994) distinguishes between situational and abstract knowing. She claims that clinical knowledge embedded in the practice of nursing has been largely ignored. One reason for this is that as expert knowledge is taken for granted, it becomes both difficult to access and to describe. Benner's work (1984) has also demonstrated that it is possible to access the detail of nursing practice. She was able to make qualitative distinctions along a novice to expert

continuum, contending that novice and experts 'live in different clinical worlds'. This notion obviously has major implications for the pupillage mode of education so favoured in the practice professions. Eisner (1991) describes a similar scenario in relation to children's learning:

> "As children mature their sensory systems become increasingly differentiated. As a result, they are able to experience more and more of their environment." (p17)

This potential discrepancy in differentiation ability may also be applicable to professional maturity and have relevance for inexperienced or novice nurses learning from experienced or expert practitioners. The situation can be explored further by drawing on the constructivist paradigm which offers one way of explaining the discrepancies. Schwandt (1994) quotes Guba and Lincoln (1989) who claim that:

> "The nature or quality of a construction that can be held depends upon the 'range or scope of information available to a constructor, and the constructor's sophistication in dealing with that information."
> (p129)

Although spoken from a visual arts perspective, Eisner's (1991) words further clarify the complexity of experiencing something and constructing an understanding or meaning as a consequence:

> "Seeing, rather than mere looking, requires an enlightened eye: this is as true and important in understanding and improving education as in creating a painting." (p 1)

Eisner's work aims to broaden views about knowing with the intention of illuminating the educational experience.

It is this potential range of meaning that will be explored in this study with the intention of identifying education that will 'enlighten' the learners' vision. It is not intended as an alternative to the science based knowledge which is acknowledged as being essential to nursing, but adding a complementary knowledge dimension. This more comprehensive approach may then be able to more effectively capture the skills and artistry of nursing.

Summary: what is there to understand about nursing

The theory implicit in many practice professions, including nursing, is not well established. There has recently been an increasing number of attempts to capture it, exemplified in the development of the field of knowledge elicitation research. Eraut (1994), a very influential voice in the field cautions that articulation of practice knowledge is not simply a matter of asking practitioners to voice it. However, a number of researchers, notably Schon (1987, 1991), have reported success in this endeavour, drawing considerably on reflection to aid their work.

Historically, the technical rationality model has been the dominant nursing knowledge paradigm. Indeed it has been the dominant paradigm in virtually all fields of knowledge for most western society since Descartes. However, this over riding control is being challenged and there is an emergence of thinking across a range of disciplines suggesting that we need to reconsider the situation. An approach to knowledge that acknowledges dialoguing with practice as a source of knowledge is developing, giving credence to the ontological perspective of knowing. Research into professional practice is now beginning to explore the

possibility of making practice knowledge explicit and consequently more accessible to criticism, dissemination and development. This research suggests that it need not be a choice between practice generated knowledge or science based knowledge, but that it is now appropriate to acknowledge that both contribute to the knowledge base of nursing. Watson (1988) suggests examining the :

> "inner world of experiences rather than the outer world of observation... This different path can expand our limited thinking and allow us, as professionals and scholars, to develop new pictures of what it means to be human, to be a nurse...(p8-9)

These changing approaches to understanding practice, linked to the concept of constructed knowledge are significant in the framing of the current research question and process.

This study aims to contribute to knowledge development by detailing the meaning of practice experience of students and qualified nurses. As this field of research is just evolving, development of the means of expressing practice meaning and knowledge will be inherent in the research process.

HOW CAN EDUCATION BE APPROACHED ?

Styles and philosophies guiding the programmes of preparation for nurses have varied over time and are related to the predominant knowledge paradigm. Placing the current approach within a historical context is necessary before considering theories of education practice that are closely related to interpretations of 'knowledge'.

Styles of nurse education

Schon (1987) has described a 'crisis in confidence' in professional education :

> "What aspiring practitioners most need to learn, professional schools seem least able to teach." (p8)

A number of practice professions, nursing, social work and teaching, are currently scrutinising their approaches to practitioner education. In particular they are reviewing the domination of technical-rational approaches. Rolfe (1996) suggests that the continuing existence of the theory/practice gap is an indication that the technical-rational paradigm is inappropriate for nursing. Gould and Harris (1996) therefore note that a:

> "...re-evaluation of traditional orthodoxies concerning the nature of practice knowledge and its relationship to education and training of practitioners." (p223)

is taking place.

Bines and Watson (1992) identify three models of professional education -

- the pre-technocratic or apprenticeship model
- the technocratic model
- post-technocratic model

It is possible to trace each in relation to approaches to nurse education. Nursing had a strong allegiance to the apprenticeship and technical rationality models. Although the apprenticeship approach had been challenged piecemeal for some years, particularly by undergraduate nursing programmes, the largest proportion of the nurse education programmes were given over to placement in the clinical setting, interspersed with periods of theoretical study. Until *'A New Preparation for Practice'* (1986) students were also regarded as part of the clinical work force rather than supernumerary learners. Nursing's links with medicine and its struggle for professional and academic status also encouraged an affiliation to the technocratic approach. Under this influence education is typically provided by three types of teacher; 'pure' subject specialists, former practitioners now specialising in the interpretation or application of pure theory to professional practice and the practice teacher or mentor.

The post-technocratic approach is still in the developmental stages with a growing emphasis on the practicum. Knowledge and theory are seen to be constructed or created rather than discovered. The subject specialist role as an interpreter of theory is diminished, with a growing partnership between educators and practitioners.

Irvine (1995) summarises the last decade of nurse education by identifying the change from knowledge transmission to learning facilitation. According to Smith

(1992) :

> "Learning is purposeful, active and personal. What one comes to know through the process of learning evolves from the thought that goes into efforts to construct meaning." (p52)

Effective learning is seen to be 'meaningful' in terms of the interaction between new information or experience and knowledge or perceptions already held.

Over time there have been differing views on the role of practice in nurse education. Debates have developed over whether practice provides the learner with a forum to apply the pre-learned theory or whether it provides an environment in which to develop theory. Fish, Twinn and Purr (1989) support the latter and define learning *through* practice as:

> "...the placement is used not as a way of mastering the given but as a vehicle 'through which to learn something wider and of more significance'." (p13)

There is a growing emphasis on practice as the foundation for nursing knowledge and education.

Practice based professions such as nursing use a number of modes of preparation /education. Nursing relies considerably on pupillage. This involves spending time with and learning the craft from an 'expert' or at least a more experienced practitioner. This form of teaching / learning places low demands for explicit articulation of process or theory driving practice from the 'expert'. Research by Benner (1984) also places some doubt on the ease with which learning from an expert or significantly more experienced practitioner can occur. She has identified a novice to expert practice continuum and contends that novices and

experts live in different clinical worlds. With reference to clarifying the practice of medical diagnosis, Gale and Marsden (1983) quote de Groot (1965) to illustrate the problem of experts teaching learners:

> "...the more experience a person has collected in any field, the more difficult it becomes for him to understand the behaviour of have-nots." (p2)

The Community Health Nurse (hereafter CHN) sample in this study are not necessarily being given the 'expert' categorisation in Benner's sense of the term. However, they have certainly undergone post-registration education and have been exposed to more experience of nursing practice than the student sample.

These comments raise the questions 'how should nurse education be developed in the future?', 'which approach/es should be favoured?' One important criteria is the reduction of the theory-practice gap. Tolley (1995) stresses the importance of this task:

> "If academics and practitioners cannot reduce this divide and communicate their ideas, then the future of nursing is at risk." (p187)

While discussing the future of nurse education, Macleod Clark (1998) stressed that a symbiotic relationship between education and practice should be engendered to address the problem of the theory / practice gap.

Our success in preparing nurses to respond to changing health care demands is another aspect of nurse education which Macleod Clark questions. She predicts

that the move to primary health care will gain momentum, but cautions on our progress to accommodate to this to date:

> "We must also acknowledge that, although in theory students are being prepared to work in primary health care settings, the reality is that most have very limited exposure to nursing in the community." (p16)

One option would be to expand exposure. This move would be based on the assumption that increased exposure to practice results in increased learning, an argument that is open to question. However, given the current high demand for primary health care placements, this is not even a realistic option. If the quantity of experience is unlikely to change significantly, we must address the quality of learning which occurs. The message must surely be that if exposure is limited, it is crucial that maximum use is made of that experience.

Richardson's (1992) comments in relation to physiotherapy are also pertinent to nursing. She identifies the importance of investigating practice to ensure education programmes provide appropriate and relevant frameworks for practice:

> "Educators need to know how practitioners today discern the meaning of events .....Findings from qualitative research into this kind of situational understanding will help educators gain a clearer idea of the realistic needs of the novice practitioner...." (p24)

Such knowledge may heighten students' preparation for clinical learning experiences.

In a similar vein, Diekelman et al (1987) suggest an alternative to the 'technical rationality' model of nurse education is the 'dialogue and meaning'

model. Where:

> "The focus of clinical experience moves away from the application of previously learnt theoretical knowledge to a process of understanding the meaning and context of the nursing situation...." (Davies 1991:166)

This 'dialoguing' concept has a language connotation, raising the question: 'Do theory and practice use the same language?' Miller (1985) suggests that the languages of practice and theory are divergent and identifies this as a contributor to the theory/practice gap. The English National Board (ENB 1997) has recently called for education to use 'practice language'. These issues are influential in the decision to use a phenomenological framework to guide this research process, to allow the meaning of practice for practitioners and learners to be voiced in their own words, using their language.

Experiential learning

The recent growth of interest in experiential learning is not a new development in education, for example Dewey wrote '*Experience and Education*' as far back as 1938. Experience is central to his definition of education:

> "It is that reconstruction or reorganization of experience which adds to the meaning of experience, and which increases ability to direct the course of subsequent experience." (Dewey 1966:19)

A second key contributor to the field in the 1940s was Lewin (1952) who developed a four-stage learning cycle; concrete experience, providing the base for observations and reflection, which are then assimilated into a theory from which implications for consequent situations are deduced. The French psychologist

Piaget (1973) also made a significant contribution to experiential learning theory in relation to young children. He described intelligence as being shaped by experience and identified age-related reasoning processes. It may be that this age-related concept may have some potential use when making comparisons with Benner's work. For example, Benner (1984) identifies differences in the reasoning process of novice and expert nurses. This differential may have implications for the learning process encouraging us to acknowledge the potential impact of 'professional age' on experiential learning.

What exactly is 'experiential learning'' ? It is defined by Kolb (1984) as:

> "...the process whereby knowledge is created through the transformation of experience." (p38)

and knowledge is described as:

> "...being continuously created and recreated, not an independent entity to be acquired or transmitted." (p38)

Bolt and Powell (1993:5) refer to Cell (1984) who alerts us to the possibility of dysfunctional experiential learning where misinterpretations may be made. Warning that:

> "...we often manipulate our experience to fit our beliefs.....we simply impose our maps upon present perceptions, endlessly renewing the mistakes, the distractions, the particularities of our past learning."

This is a good description of the sometimes 'messy' nature of human learning. However, since we are aware of the problem, we could at least adopt approaches that seek to minimise dysfunctional and enhance effective learning.

Eisner (1991) explores this issue further in his discussion on our ability to perceive the different qualities inherent in any experience:

> "We often tend to experience qualities as labelled objects: "tree", "chair", "classroom", "teacher" and so forth. That is, we move almost instantaneously from the qualities we are able to see to their classification and labelling. We categorise. Of course, categorisation is useful: by categorising we know the "species" of our experience. But categorisation can also be a liability when it forecloses, as it often does, the exploration of qualities that constitute this classroom, that student, this particular school. If our perceptual experience is aborted for the sake of classification, our experience is attenuated; we do not experience all that we can." (p17)

It is clear therefore that several factors may mediate in the learning that occurs as a consequence of experience. Gould and Harris's (1996) discussion on student imagery may be relevant here. They draw a comparison between students imagery of social work and teaching, suggesting that every student will have experience of observing teachers, but few will have experience of observing social workers. Their imagery of the two professions will therefore be affected. It is probably fair to say that most students enter nurse education with a image of the nurse practising in the hospital setting. This may influence the categorisation of experience of nursing in the community context.

In Eisner's (1991) view perceptual differential is a key element to experiential learning. The role of perception in well acknowledged in fields such as art, music, literature. Its role in a practice profession such as nursing, where aspects of practice must be guided by fact rather than perception is perhaps not so obvious. There are aspects of nursing which do not allow for perceptual assessment. For example, vital signs such as pulse and blood pressure have an

explicit acceptable range, they are not open to perceptual negotiation. However, it can be argued that perceptual experience has a role in nursing and in learning to nurse. Nursing is a complex activity, it is more than the sum of the practical skills performed in the course of care delivery. Nursing in the community context may impose additional dimensions on the process. Comparison of the perceptual awareness of students and CHNs as demonstrated in their constructions of the meaning of practice will shed light on the relevance of this issue for nursing.

Alongside the developments in experiential learning has been a rising interest in the constructivist knowledge perspective that supports the view that knowledge is constructed rather than discovered. Higgs and Titchen (1995) describe the process:

> "...individuals create unique constructions or interpretations of nature and of their own experiences and that knowledge is the product of a dynamic and indeed difficult process of knowing or striving to understand." (p130)

Kolb (1984) suggests that learning occurs through the transformation of experience. A cyclical activity of experience - learning - reflection - action is identified. There has been some criticism however, of the limited exploration of exactly what is meant by 'experience'. Although also endorsing the role of experience in learning, Jarvis (1987) makes a distinction between experience and a situation. He suggests that experience is created through subjective definition of a situation. He draws attention to the possibility that not all experience is meaningful for the participant, indeed some experience may be meaningless. Without meaning the learning process will not progress. McLeod's (1990)

research focuses on exploring 'experience' in nursing. She highlights the limited examination of experience as a component in the experiential learning process, commenting that:

> "...although models are grounded in experience, the theorists do not excavate that ground" (p9)

The phrase 'excavate the ground' is rich in meaning for this research and helps to articulate the level at which the research is focused. It is concerned with articulating and exploring the experience of nursing in a community context. It may then be possible to add to our understanding of community as a context for practice and the educational needs of learners.

Reflection

A close companion of experiential learning is the concept of reflection, a vehicle for learning from experience by developing new understandings or appreciations. Although learning may develop from experience, experience need not necessarily result in learning. Something has to be 'done' with the experience to make it educationally productive. Boud, Keogh and Walker (1989:7) define reflection as:

> "...an active process of exploration and discovery"

It is a purposive process with a number of phases. Again, to quote Boud, Keogh and Walker (1989:19):

> "Reflection is an important human activity in which people recapture their experience, think about it, mull it over and evaluate it. It is this working with experience that is important in learning."

As a consequence of his work on the concept of reflection, Schon (1987, 1991 1992) proposed an epistemology of professional practice, raising the status of knowledge developed in practice through reflection. Essentially he purports that our knowing is in our action/s. He appreciates that much of our understanding of practice is at an unconscious level. However, according to Schon, through deliberate reflection we can become more aware of what we know. In his book *'The Reflective Turn'* Schon (1991) presents a collection of examples of reflective practice. It adds to what he terms the practice or education 'revolution' which in his words:

> "...offers, as a first-order answer to the question, What do practitioners need to know?, reflection on the understandings already built into skilful actions of everyday practice." (p5)

Examples are provided of teachers trying to "get in touch with and influence" students evolving understanding. One account of particular relevance to this research is Erickson and MacKinnons' (1991) discussion of an experienced and a novice teacher. Although related to science teaching the authors believe that it has relevance to learning what they call the 'underlying' knowledge of other types of practice as well as teaching. They identify learners as:

> "... purposeful sense-makers - constantly engaged in the task of *constructing* ideas to make sense out of the situations they encounter." (p16)

They suggest that appreciation of this concept could improve teaching design and delivery. A key element is how the teacher can make their knowledge, which is often routine and tacit, explicit to the learner. Erikson and MacKinnon suggest that a 'showing and telling' interaction between learner and teacher is the most

effective approach. Indeed they report that the experienced teachers in their study actually found working with a novice facilitated the unpacking of their practice understanding. This approach links very closely to the perception that experience alone does not result in learning, learners must construct a meaning from the experience. Acknowledging that any experience can be seen in different ways they support a constructivist approach to teaching.

In a similar vein, Bamberger's (1991) work focused on developing multiple representations of knowledge. She begins her chapter with a quotation that touches the essence of reflection in the construction of meaning from experiences. The quotation is reproduced below:

> "Reflections are *made* by the reflecting surface.
> Even mirrors are only rarely passive;
> They transform images - enlarging, diminishing, dimming,
> reversing, bending, twisting -
> In implausible, unpredictable ways...
> Until you learn to follow the (sometimes circuitous) but always
> Orderly course the reflector takes
> In reflecting back the sending beam." (p32)

Bamberger (1991) argues that although reflection may take place, it is often transparent. She attempts to address reflection on actual practice that is not distorted with what she terms 'historical revisionism'. Her study focuses on assisting children to engage in different types of learning, for example, practical, technical tasks and language skills. She set out to:

> "...encourage them to actively *confront* differences and similarities that emerged as they move across materials, sensory modalities, and kinds of descriptions. (p39)

Bousefield's (1997) comments about nursing being a 'pluralistic society' and a multi-value profession and Kenyon et al's (1990) comments about the distinctiveness of community come to mind here. The pre-registration nurse education programme consists of a variety of different experiences. The logic is that students are exposed to different experiences because there are different things to learn in different contexts of care. Bamberger's technique of confronting the differences, as well as the similarities, between practice contexts would therefore appear to be pertinent to nursing.

Hallett (1995b:83) draws on the concept of reflection in her research and describes it as being aware of our own thought processes. She highlights the psychological theory of metacognition which "involves cognitions about cognitions...". This idea of building on understandings to develop a more complex picture of what we know is returned to again in the chapter on data interpretation.

Summary: how can education be approached ?

Approaches to nurse education have changed over time, moving from a knowledge transmission focus to an approach that also endorses learning facilitation. Bines and Watson's (1992) overview of models of professional education helps to clarify the move to closer scrutiny of the theory embedded in professional practice. In order to facilitate this practitioners require interpretive theories to articulate their practice, some of which may be tacitly understood.

Several writers (Kolb 1984, Jarvis 1987, Fish, Twinn and Purr 1991) have reviewed the role of experience in learning. It is acknowledged that learning is not an automatic consequence of experience. There must be engagement in purposeful acts of learning creation. Allen, Benner and Diekelman (1986:28) suggest that in Heideggerian terms experience is not about "...the mere passage of time, but a turning around and refining of preconceptions." There has been limited exploration of experience as part of the learning process in the field of nurse education.

Macleod Clark's (1998) identification of the problem of limited exposure of students to community experience intensifies the problem facing this aspect of nurse education. Any means to enhance understanding of the learning which can take place in practice would be helpful. The increasing focus on community as a context for practice also needs to be acknowledged. It could be argued that this concept places an additional challenge to the dominance of the technical rationality paradigm.

In response to the current debates and trends in nurse education, specifically in relation to education for community practice, this research aims to explicate and compare how students and CHNs construct their experience of nursing in the community context.

WHAT IS THE PURPOSE OF PRACTICE PLACEMENTS ?

Several professions include practice or clinical placements as a mode of professional education. According to Rolfe (1996) the practicum is a central focus in education approaches which acknowledge that technical rationality cannot be the only or dominant paradigm. However, Bines and Watson (1992:21) identify that:

> "Despite its new centrality to professional education.....the practicum remains the least developed element of most courses."

This section discusses the role of practice placements in professional education and identifies what learning and teaching may take place. The discussion is then focused specifically on placement in the community setting as an element of pre-registration nurse education.

Practice placements as part of professional education

Earlier discussions have identified distinctions between theoretical and practical knowledge or theory and practice. In nursing the valued form of nursing knowledge has been the formal, theoretical type, with education historically having a technical-rational base. However, recently the situation and the value system has been changing with greater recognition of the knowledge embedded and developed in practice. Although enhanced value may be placed on this aspect of education, this does not automatically prepare practitioners for the change. As a by product of the theory/practice gap, practitioners may struggle to

see themselves as theorists (Ramprogus 1995, Rolfe 1993). According to Tolley (1995):

> "For practitioners to see themselves as having this wealth of knowledge embedded in practice, they need an awareness of practice theory itself and the research methods used to develop this. Practice theory needs to be sold to practitioners, who need to see the possible benefits of it for their clients and nursing." (p187)

The recent upsurge in evidence based health care and the development of clinical governance could potentially have a number of impacts on practice theory development. The demand for science and rigour may challenge the recognition of practice in favour of a return to the empirical knowledge dimension. There is therefore a need for educationalists and in particular nurse educationalists to identify what can be learned from the practice setting that is distinct from the codified, book knowledge element of the education programme. However, the current climate of limited placement availability may also provide an impetus to more clearly establish exactly what learning should take place during the practice placement of education programmes. In research exploring the education role of community nurses commissioned by the ENB, Thomson et al (1996) report that quantity of practice placements vary between education programmes around the country and appeared to be driven by availability. A more appropriate rationale is obviously necessary.

There is increasing support for the contention that theory comes from practice, for example, curricula in nurse education are now drawing considerably on the work

of Eraut (1985, 1994), Schon (1987) and Benner and Wrubel (1989). According to Eraut (1994):

> "...it is inappropriate to think of knowledge as first being learned and then later being used. Learning takes place during use, and the transformation into a situationally appropriate form means it is no longer the same knowledge as it was prior to it first being used." (p20)

Visintainer (1986) claims that nurses are more than consumers of theory or appliers of information that comes ready packaged for use. On the contrary, nurses should be recognised as agents who assemble the package of information, utilising a variety of theoretical perspectives. This process of using knowledge takes place in clinical practice and must therefore be one of the items on the learning agenda. The process, packaging element also deserves attention, but may not be very visible to the learner.

Erikson and MacKinnon (1991) describe learners as purposeful sense makers, constantly engaged in the task of constructing ideas to make sense of the situations they encounter. What an individual sees is determined by their particular cognitive frame that allows them to interpret each situation. Meanings are context dependent, and accurate interpretation of meaning relies on understanding the framework guiding practice in that context. Learning and teaching could therefore be perceived as a process of exploring and organising the world. Different participants in the learning situation may develop different representations of reality. Research carried out by Mattingly (1991a,b) examining the practice of occupational therapists accepted the assumption that any

representation of action should also be viewed as an interpretation, one possible story among several that could be told.

This concept of 'sense making' is significant in the development of this study. It focuses the research question to the 'sense making' occurring in community nursing practice and has implications for the strand of interpretive research that may assist to design the research.

Through articulation of practice detail or uncovering the 'sense' of nursing actions it may be possible to address the issue of learning through and from practice. In their discussion of improving the effectiveness of social work and teacher education, Gould and Harris (1996) suggest that students should be assisted to articulate their initial frame of reference. While endorsing this view, it may also be necessary to consider not just initial frames of reference, but developing frames of reference as the education programme progresses and different experiences are encountered.

In addition to the arguments about what can be learned in practice, there is support for the assertion that learning does not necessarily happen just by being placed in the clinical setting. However, as Thomson et al (1996) point out:

> "...the processes through which students of nursing are assisted to learn through practice remain poorly understood." (p14)

The work of Fish, Twinn and Purr (1989, 1991) has contributed to exposing how students can be enabled to learn through professional practice with the production of a guide to facilitate learning through reflection. Schon (1991) in his book *'The*

Reflective Turn' provides a compilation of papers that attempt to give reason to practice and illuminate the process of practice and learning to practise.

There are therefore two issues; 'what is to be learned' and 'how it is to be learned'.

Miles (1987) describes the experiential learning cycle which is presented in Figure 5.

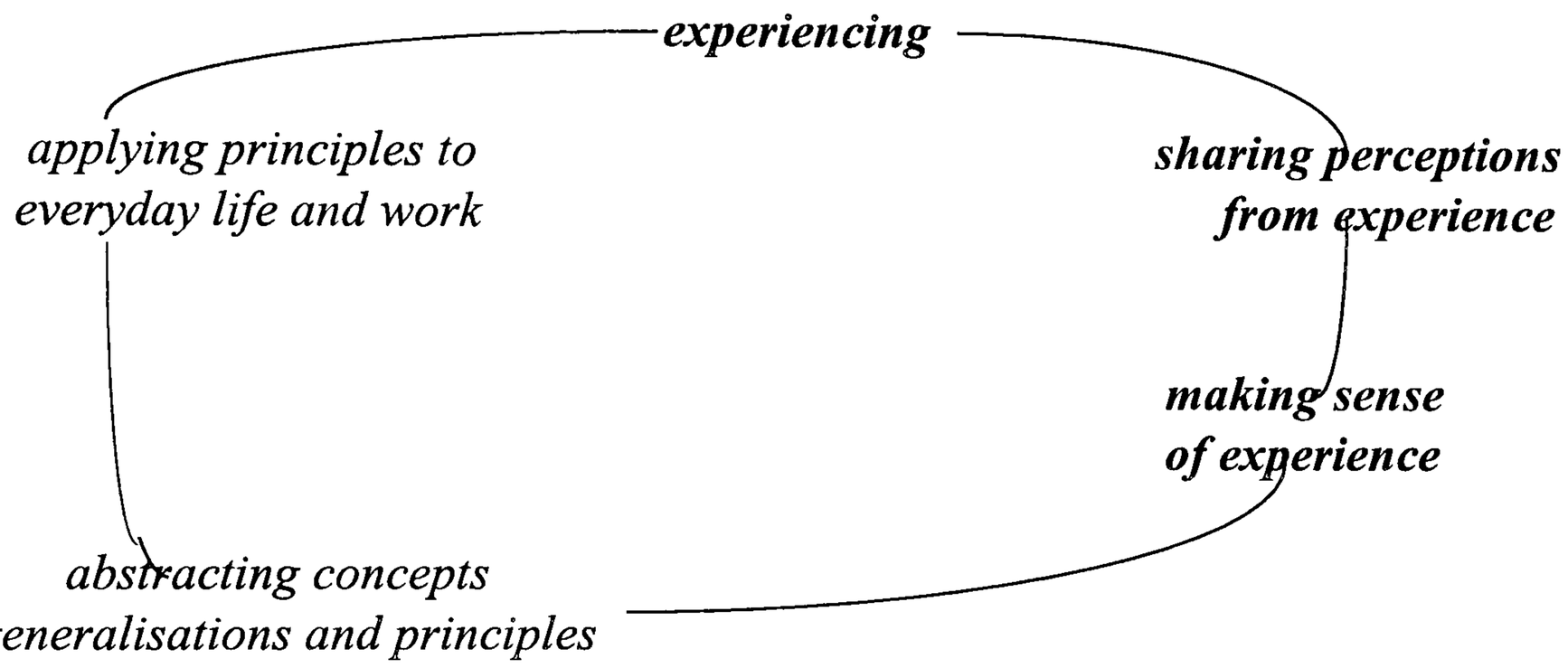

Figure 5 Experiential learning cycle

Those components of the cycle identified in bold print are seen to provide the focus of this research. In view of the research reported by Fish (1989) it would appear that this is a neglected area of clinical practice education, with a tendency to resort to propositional knowledge to make sense of experience rather than developing knowledge or understanding from the experience itself. This research will contribute to addressing these deficits.

Goodman (1978) writing on 'ways of world making' helps to explicate the complexity of the situation. He gives an example of someone sitting in a waiting room, initially unaware of the presence of a stereo system. When the person does identify the system, they have found something that was actually there all the time. He breaks the process down into stages presented in Figure 6 .

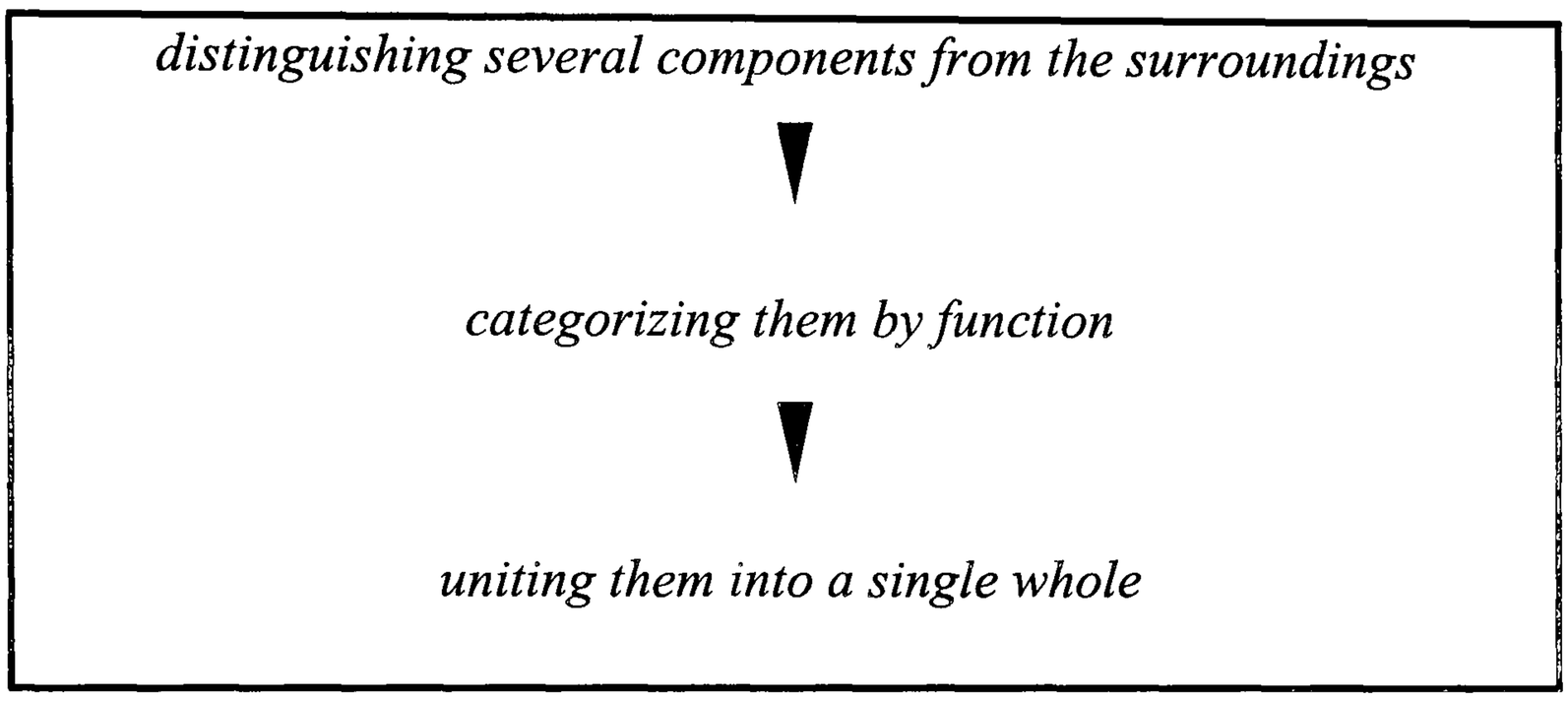

Figure 6 Process of world-making described by Goodman (1978)

Goodman goes on to suggest that if someone else sat in the room, say someone used to living in the jungle, they would not find the stereo because:

> "he has no means of making any stereo system in that room." (p30)

Although student and CHN may not approach the world from such diverse perspectives, this process of making sense of experience or 'world making' may be useful in describing the different experiences of student and CHN.

Moving on from the possibility that CHN and student may make different worlds, the next issue to address is what are the means of world making? What is it about nursing in the community 'world' as opposed to the hospital 'world' that is

important to the experience. What aspects of the world (cf. the speakers and turntable in Goodman's example) need to distinguished? Visintainer (1986) says that:

> "The definition of a knowledge base for a discipline begins with the separation of that knowledge which is important to the discipline and that which is not: the kernel from the chaff, the essential from the trivial, the main effects from the random error." (p32)

This begs the question of what extra dimensions of knowledge can and should be developed as a consequence of experience in the community context. There is a need to explicate what can be learned in practice and how this learning can be facilitated. The next section develops this discussion by focusing on clinical placements as part of nurse education.

Learning and teaching in the practice setting

The education programme of several practice professions involves theoretical/college based and practice based components. The purpose and process of this aspect of education is the subject of considerable debate. According to McLeod (1990) :

> "Knowledge that is practical, intuitive and experiential has lost ground in nursing to knowledge that is more scientific and theoretical" (p28)

However, Twinn and Davies (1996) highlight a growing emphasis on learning theory through professional practice. There is a movement in nurse education curricula away from the technical rationality model towards the practice component of education. The pace of change however, is rather slow. For

example, in a recent survey (Thomson et al 1996) of community practitioners experience of teaching students it was reported that respondents:

> "...were unable to articulate how they helped students to make links between theory and practice." (p4)

This suggests that a knowledge application version is perpetuating and is perhaps dominant. Interestingly the respondents identified the linkage difficult because:

> "...they did not know what theory had been, or was being, taught." (p4)

This comment highlights the complexity of learning in the clinical environment when the health care and education establishments are separate entities. It also calls into question why, if it were practice relevant, the theory should not be familiar to the practitioners. To refer back to the ENB (1997) comments about using practice language, it may be that the theory in its current presentation format is not recognised by the practitioners. This scenario appears to be a far cry from the 'symbiotic' education/practice relationship advocated by Macleod-Clark (1998) and gives some indication of the amount of work needed to achieve this type of relationship.

Benner (1984) explicates the role of theory in a practice profession suggesting that theory guides the practitioner but does not determine practice :

> "...theory tells the practitioner where to look for problems and how to anticipate care needs." (p178)

Practice or clinical placements could therefore be perceived as a time when students learn to form a frame for their practice. The relevance and purpose of such placements needs to be specific and clearly defined.

Recent changes to pre-registration nurse education have resulted in a significant increase in the amount of time students spend on placements in the community. Placements are therefore at a premium as they are also in demand from a range of health and social care learners. Economic and supply constraints demand that the purpose of the placements are clearly defined. However, one of the issues identified in Orr and Halletts' (1993) research was that practitioners were unsure as to the purpose of student placements with community staff and the aim of the experience. Thomson et al (1996) describe the new education role for community nurses as 'ill-defined'. The new course demands a significant shift from the former situation where students were on placements to *observe* the role of the community practitioner, now they are on placement to *learn* to become a community practitioner.

Mentorship and professional role models are another two important issues to consider in this discussion. In a hospital setting, students are allocated a staff nurse (qualified first level nurse+) to act as their mentor. If, on graduation the student chooses to work in a hospital setting, s/he would be employed as a staff nurse+ i.e. the same type/grade+ of post as their mentor holds. However, in the

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+ see glossary

community setting, students are allocated a specialist practitioner+ to act as their mentor, someone who has undergone further education and who holds a post-registration qualification (a work force of specifically educated community staff nurses does not yet exist). If on graduation the student chooses to work in the community setting, s/he would be employed as a first level nurse and could only take up a specialist practitioner post after further education. In hospital a degree of role modelling is therefore appropriate. However, in the community setting the role parameters are as yet unclear. The current absence of a community staff nurse specifically educated for the role means that students may be allocated a mentor, but this mentor does not provide a role for the students to emulate. This situation is also being experienced by other learning/teaching partners as health care roles are being challenged. Nurse practitioners for example, because it is a new and developing role are often mentored by General Practitioners, in the absence of an established nurse practitioner workforce. This type of mentor /learner relationship relies on clear articulation of the appropriate components of role and each party involved having a subjective understanding of the other party.

Hallett (1995b) refers to Schutz's work on 'streams of consciousness' to further explicate this issue. The development of a 'we-relationship' allows understanding of the other's situation:

> "As both parties comprehend the consciousness of the other they experience 'simultaneity' and may achieve genuine intersubjective understanding" (p169)

However, the possibility of achieving this type of understanding and

intersubjectivity between CHNs and students must be questioned on a number of dimensions. Benner, Tanner and Chesla (1992) summarises the potential problem saying that:

> "...practitioners at different levels of skill acquisition literally live in different clinical worlds." (p14)

Silverman's (1993) discussion of interviewing and world construction has something to offer this teaching / learning scenario with the participants potentially living in very different clinical worlds. He quotes Baker (1982) :

> "When we talk about the world we live in, we engage in the activity of giving it a particular character. Inevitably we assign features and phenomena to it and make it out to work in a particular way. ...When we talk with someone else about the world, we take into account who the other is, what that other person could be presumed to know, 'where' that other is in relation to ourself in the world we talk about." (p109)

This has little in common with the understanding practitioners had for students in the research discussed earlier (Thompson etal 1996). It also contrasts quite dramatically with Schon's notion of 'learning bind' referred to by Fish, Twinn and Purr (1991) where they recount practice teachers and students *talking* to each other, but not *listening* to each other [*my emphasis*].

The 'activity of giving [our world] a particular character' has implications for Mattingly's (1991b) statement that experience can be an inconsistent teacher. In other words it is possible to live through something and either learn very little or not learn what is specifically expected of you. A quote from T.S. Eliot is worthy of consideration:

> "We had the experience but missed the meaning".

England (1986) identifies that social workers have difficulty in explaining what they do, even to themselves. The capacity for sharing the detail of practice with a student may therefore be limited. There is the potential to miss meaning, but perhaps of even more concern, teacher and student could be unaware that meaning had been missed. Cowley's (1991) work in relation to another community nursing specialism, health visiting, also provides useful insight. She claims:

> "Increasingly, practitioners who are concerned to articulate and evaluate the effectiveness of their practice have realised the importance of clear explication." (p648)

Her research pivots on the Health Visitor / client relationship and their perception of health needs. In order to develop effective communication she describes the health visitor as tuning into the client's wavelength. A number of dimensions of awareness context are described, for example an open-closed continuum, consonance-dissonance continuum. Cowley's work raises a number of questions for this research study, for example 'Are CHNs aware of any areas of dissonance between themselves and students?' 'How are they aware of what level of consonance has been achieved?'

Engaging in some sort of construction appears to be important. A necessary prerequisite, of course, is that we know what meanings can be accessed from the experience. In relation to community nursing this has certainly not been clearly articulated.

Observing another's practice or being exposed to a particular clinical situation is clearly not sufficient to ensure learning occurs. Indeed, imposing meaning onto experience is essential for learning and understanding the knowledge base of a profession (Jarvis 1987). In relation to clinical stories and their translation, Stein and Apprey (1990) refer to a dynamic model of understanding and teaching when doctors responded to patients. They suggest that it is possible that :

> "...there exists an implicit story beneath the official, explicit one." (pxiii)

This model may also have implications for translating teaching/learning dialogues in the practice setting. There may be layers of meaning or multiple stories within a practice episode. This is similar to the earlier discussion of Goodman's (1978) ways of world making (Figure 6). Both CHNs and students may require some degree of facilitation in order to reveal the story/ies of their practice experience in a similar way to Polanyi discussed the development of a photo-fit tool allows someone to describe the features of a face. This research aims to access the story of CHN and student experience of nursing in the community context and to explore whether there are both implicit and explicit levels of articulation and understanding.

Summary :what is the purpose of practice placements?

Learning and teaching in practice is more than facilitating the application of codified theory. It is now being recognised as an opportunity to explore, develop and organise practice theory. However, the learning which could develop as a consequence of exposure to the clinical situation has not been clearly explicated.

With respect to pre-registration community nursing education, this situation is exacerbated by the vagueness of the new community staff nurse role which is still being developed.

The 'pre-registration' status of the students also means that the majority of their clinical placement will be in the presence of the qualified nurse i.e. they will rarely visit alone. This provides a rare opportunity to explore student and qualified nurse's experience of the same clinical situation. This is only possible because of the changing paradigms guiding nursing research which are explored in the next section.

HOW CAN NURSING AND EDUCATION BE RESEARCHED ?

As this research focuses on practising and learning to practise nursing, previous research from both education and nursing has been addressed.

Nursing and education research - changing paradigms

Although still endorsing the positivist perspective, nursing and education research have now embraced humanistic and naturalistic approaches (Benner 1985, Leninger 1985, Melia 1987, Morse, 1991, Darbyshire 1994a Hallett 1995b). This reflects the growing endorsement of the ontological perspective on knowing which is summed up by Watson (1988) :

> "Nursing is undergoing a questioning process as to whether it should continue to align itself with traditional science to improve practice or to abandon science in favour of some other approach to reality." (p9)

Eisner's (1991) work discussing the use of qualitative paradigm approaches in education has been particularly helpful in developing the current research question. He suggests that naturalistic approaches can contribute to broadening our understanding of what it means to know. He refers to 'getting in touch' with the natural state and suggests that :

> "...if qualitative inquiry in education is about nothing else, it is about trying to understand what teachers and children do in the setting in which they work." (p11)

England (1986) claims that it is very difficult to find out what social workers do.

Merely asking them elicits replies such as 'visiting people', 'helping people'.

Responses such as these provide limited insight into the practice of social work. The detail is shrouded in a broad labelling of the activity. There have been a number of studies of nursing practice that simply focus on identifying the types of tasks carried out by the nurse. However, it is the detail of what the practitioner does, why they do it and how they know what to do, that is required to develop novice practitioners and for practitioners to share their practice knowledge in situations such as clinical supervision. The situation is summed up by Rolfe (1998:30) using a plumbing example. He describes a scenario where a plumber charges £100 for a 30 second job of hitting a pipe with a spanner to resolve a central heating problem. The itemised bill read :

> "Hitting central heating pipe with a spanner £1
> Knowing how, when and where to hit it £99"

Rolfe (1996) suggests that what is required is :

> "...a model of research that will uncover and make sense of informal theory, theory that is generated directly out of practice..... a model of research that will formalise the process of reflective practice and elevate the status of informal, tacit, 'intuitive' knowledge and theory to the same or greater level as formal, research-based knowledge." (p56)

Nursing's endorsement of naturalistic approaches is exemplified in the work of researchers such as Benner (1984), McLeod (1990), Darbyshire (1994a), Taylor (1993, 1994), Hallett (1995a,b), to name but a few who have been influential in the development of this research. These researchers have all followed various interpretive perspectives to address their research questions. Wilson and

Hutchinson (1991:264) identify the development of methodologies which have allowed nurse researchers to "illuminate personal meanings and practices or behaviours from the perspective of health care consumers." In line with the earlier discussion on 'world-making', the notion of illuminating meaning is important for this research. While being guided and influenced by the developments described by Wilson and Hutchinson, this study utilises the approach with a different focus. The 'consumers' in this research are the CHNs and the students, the consumers of the experience of practising and learning to practise nursing in a community context. In relation to the growing interest in phenomenological research Hamill (1994) believes that :

> "Nurses can only start to understand a patient's view of things by actively inquiring into a patient's lived experience." (p511)

This research study adopts a similar philosophy and applies the same assumption to educators (lecturers or mentors) and students. Rather than comparing health care professional and patient experiences, the comparison will be of learner and qualified nurse.

The research paradigms favoured by researchers such as Benner and McLeod aim to look beyond describing nursing but to 'envision' the experience of nursing. The term 'envision' encompasses Schon's 'naming and framing' concept and Goodman's ways of world making. It accepts two participants may 'see' different versions of the same event. Such an approach is considered as best fitted to address the questions and issues identified in this literature review. One

perspective that has received considerable attention in examining both nursing practice and education is that of phenomenology. According to Rose, Beeby and Parker (1995):

> "...phenomenology methodology could become the basic instrument in the reform of nursing research as it moves from the positivist to the humanist paradigm." (p1123)

Through the guidance of the interpretive framework philosophy, the aims of this study can be refined into the specific focus of uncovering nursing phenomena. The process of 'accessing' is anticipated to be as important an aspect of the research as the meanings accessed. The term accessing is used to denote the process of facilitating articulation of each individual's constructed meaning of practice. A certain amount of method development therefore has to occur. As Eraut noted, it is not simply a matter of asking practitioners about their perceptions. Van Manen (1990) uses the term 'epistemological silence' to describe the type of silence met when we encounter the 'unspeakable'. This term also brings to mind Wittgenstein's words 'that of which we cannot speak, we must remain silent' (paraphrased). It may be that we cannot speak about something, but it could also be the case that it is our linguistic competency that limits our discourse. Meerabeau (1992) questioned whether tacit nursing knowledge was "an untapped resource or methodological headache ?" and focused considerable debate in the development of this research study. Initial hurdles to accessing the meanings of experience held by practitioners demanded considerable theoretical and methodological consideration. These issues are discussed in depth in the following chapters on theoretical framework and

research methods. However, consideration of Meerebeau's comments in relation to accessing expert knowledge, and their relation to the process of accessing meaning proved fruitful in formulating the framework for the present study. The following comments were particularly pertinent:

> "...if expert knowledge is tacit it cannot be researched by exclusively verbal methods such as questionnaires; open-ended discussion may be appropriate, or perhaps participant observation. Nor will the findings be neat and easily analysed. But tacit knowledge is also an untapped resource for co-operative enquiry between researcher and practitioner, and nursing research has an important role in enhancing the knowledge creation capacity of practitioners. (Meerebeau 1992:108)

Van Manen (1990) specifically identifies phenomenology as a perspective which:

> "...consists of reflectively bringing into nearness that which tends to be obscure, that which tends to evade the intelligibility of natural attitude of everyday life." (p32)

He uses it to address the question 'what is it like to have a particular education experience' ? He identifies that everyone is able to label their experiences, but most would struggle to describe the detail of experience. He links this deficit to education practice:

> "...in the field of curriculum we talk confidently about "selecting, planning or organizing learning experiences". This confidence begs a question - the question whether we know what it is like when a child "has an experience" or when a child comes to understand something." (p44)

The scenario described by Van Manen was replicated in this current research study. Participants did struggle to describe rather than label their experiences. The

detail of how these issues presented and were addressed will be discussed in the next chapter.

The context of nursing practice is a driving force for this research. Siting the research theoretically and physically within the community context and taking advantage of the CHN and student mutual experience of nursing requires further consideration. Review of research carried out in the clinical setting identifies some potential challenges for this research specifically because of the community context.

First, the presence of the researcher in the research setting. There is a large literature i.e. Benner (1984), Reed (1989), McLeod (1990) covering research activity in the hospital setting. There is a level of unobtrusiveness in a hospital ward that is not available in the setting of community nursing practice, i.e. the patient's home.

Second, the data collection strategies available to the researcher. Review of research exploring clinical decision making revealed a variety of data accessing techniques e.g. audio recording of the practitioner's thoughts as they carried out a procedure at the patient's bedside, video taping of the practitioner patient encounter. Again, the context of community practice may place limitations on the use of such approaches. These issues are discussed further in the research design chapter.

Summary : researching nursing ...changing paradigms

The paradigms available to nurse researchers allow us to develop perspectives on nursing further than descriptive exploration by accessing the constructed meaning of practice.

A number of examples of using interpretive perspectives to access and report the experience of health care have been reported. However, this research study uses these examples to build a framework to explore student and practitioner experiences, rather than patient and nurse perspectives. The emphasis here is to develop our education response to learning to nurse in a community context as opposed to the more traditional hospital context and to acknowledge ontological perspectives of knowing.

Summary : Overview of the literature

The multiple themes stimulating and guiding this research are summarised in Figure 7.

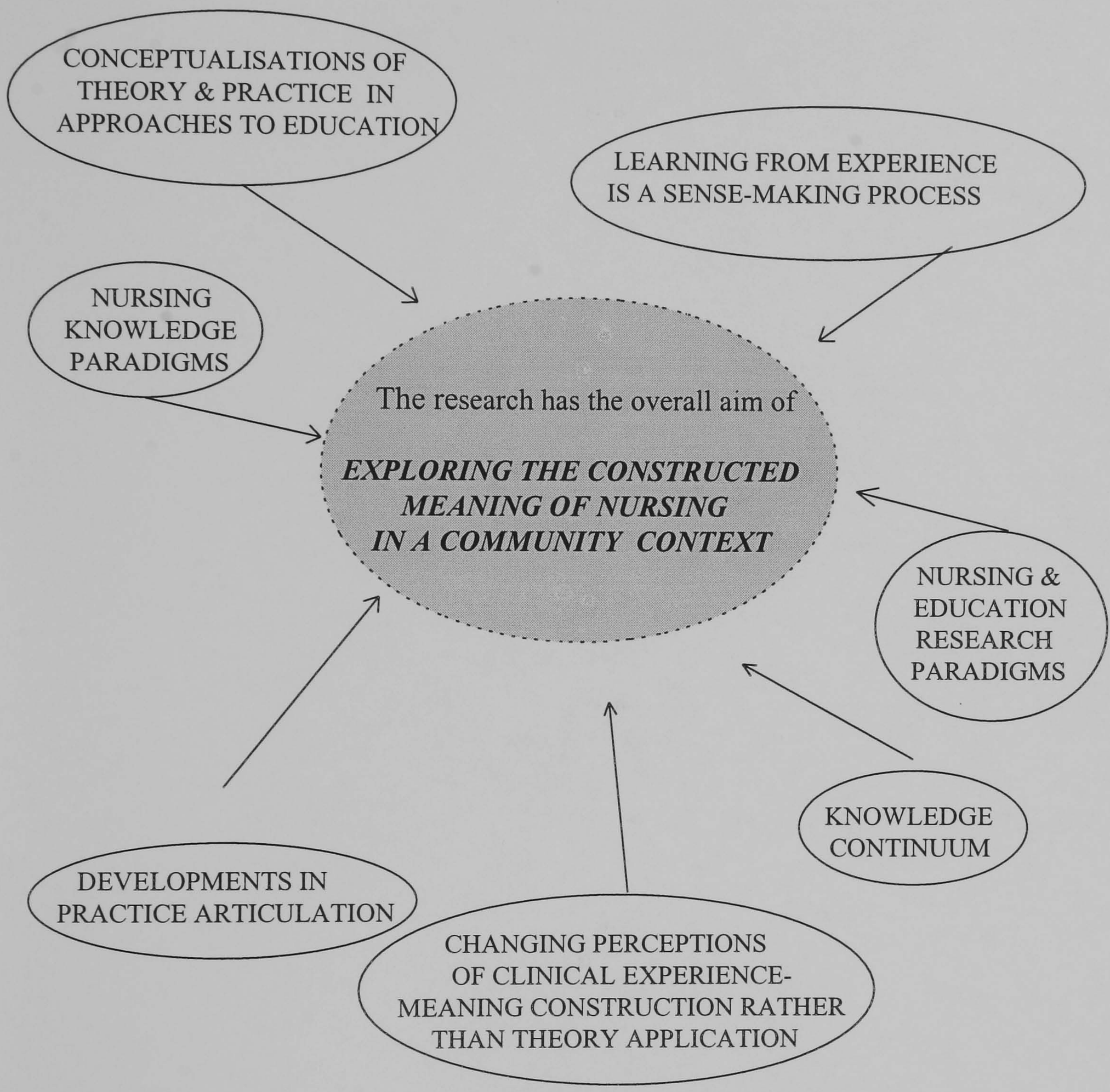

Figure 7 Themes stimulating and guiding the research

Perceptions of nursing knowledge and approaches to nurse education are undergoing review and change. Greater value is now placed on theory implicit in practice and the 'sense-making' that must take place in order for clinical experience

to be a learning experience. This development is being significantly influenced by the field of reflection and reflective practice. Both nursing and education can be shown to draw on paradigms that seek to address a wider definition of 'knowing'.

CHAPTER 3

THEORETICAL FRAMEWORK

Introduction

> "It is the theoretical framework which determines what questions will be addressed and how data will be collected. (McKenna 1997:43.)

This research is sited in the interpretive paradigm. It aims to elucidate how community as a *context* for *practice* is perceived and experienced by CHNs and students. The aim of the research is therefore to access meaning. The specific phenomena being studied are:

- students' and qualified practitioners' constructions of practice experience
- community as a context of practice and a context of learning to practise

This chapter provides a discussion of the process of identifying the specific framework that would allow the research question to be addressed most effectively; this was a complex process. It was complicated by two specific issues. First, the number of interpretive strands presented in the literature and the commonalties and similarities between them which makes distinction a difficult activity. Secondly, criticism has been directed towards phenomenological researchers suggesting that the philosophical underpinnings of much of the research are inadequately identified and often contradictory (Koch 1995, Crotty 1996). A critical exploration of phenomenology and the many interpretations of it was a pre-requisite to theoretical framework identification. Detailed discussion is therefore provided of the process of clarifying phenomenology and to the specific

perspective chosen to guide this research. An early commitment to the broad heading of hermeneutic phenomenology was reinforced as the study progressed.

The chapter is divided into two sections. Morse (1991) has criticised nurse researchers for blurring the distinctions between the different strands of qualitative research. In recognition of this criticism, the first section provides a detailed discussion of the interpretive paradigm, specifically the perspectives of phenomenology and constructivism that have influenced this research. In section two, the discussion is focused specifically on the decisions underpinning the study and a chronology of the process is presented.

Section I

What is the purpose of the research ?

This question is raised at the outset primarily to try to clarify whether phenomenology is the most appropriate interpretive option. It may be useful at this point to briefly recap on the key themes derived from the literature. Education for community practice has recently become a significant aspect of pre-registration nurse education. At the same time, community as a context for nursing practice is under researched. Dominance of the technical rationality approach to knowledge is being challenged. Specifically in relation to district nursing, McIntosh (1996) claims that:

> "...an exclusive focus on activity fails to capture the range and depth of nursing care in the home." (p316)

The developing field of knowledge articulation research and the use of reflection as a research and education tool have recently gained status. Consequently research which indicates that practice theory or understanding can be articulated has been reported (Benner 1984, Schon 1991, Benner, Tanner & Chesla 1992, McIntosh 1996) and provides some encouragement for a further exploration of meaning construction.

Paradigm options

According to Polit and Hungler (1997) :

> "Paradigms should be viewed as lenses that help us to sharpen our focus on phenomenon of interest -- not as blinders that limit our intellectual curiosity" (p16)

An initial review of potential research paradigms was undertaken to focus the research framework. Further consideration was then given to identify the most

appropriate framework to address the research question. A number of perspectives were explored and their relevance to this research study was questioned.

At a broad level research can be characterised as belonging to either the positivist or naturalist paradigm. Positivism assumes an objective, ordered existence. A reality or a version of a phenomenon is there, waiting to be identified. There is a truth, a correct version. Naturalism on the other hand would view reality as:

> "...not a fixed entity but rather a construction of the individuals participating in the research, reality exists within a context and many constructions are possible." (Polit & Hungler 1997:12)

Polit and Hungler (1997) compare the two paradigms on a range of dimensions in order to explicate their different qualities. A modified version of their comparison is reproduced in Figure 8.

PARADIGM COMPARISONS

POSITIVISM	**NATURALISM**
WHAT IS THE NATURE OF REALITY	
REALITY EXISTS, THERE IS A REAL WORLD DRIVEN BY NATURAL CAUSES	REALITY IS MULTIPLE & SUBJECTIVE, MENTALLY CONSTRUCTED
HOW IS THE INQUIRER RELATED TO THE RESEARCH	
INDEPENDENT	INTERACTIVE
WHAT IS THE ROLE OF VALUES IN THE INQUIRY	
OBJECTIVITY IS SOUGHT	SUBJECTIVITY IS INEVITABLE
HOW IS KNOWLEDGE OBTAINED	
FIXED DESIGN, DEDUCTIVE PROCESS	FLEXIBLE DESIGN INDUCTIVE PROCESS

Figure 8 Paradigm comparisons (modified from Polit & Hungler 1997:13)

Previous remarks about experiential learning, reflection and constructed meaning steer this research in the direction of the naturalistic paradigm.

Adoption of a naturalistic paradigm, also referred to in the literature as the qualitative or interpretive paradigm, is only the first step in the theoretical framework decision chain. Differentiating the appropriate strand or strands of this paradigm is the next step in the process.

Overview of the interpretive paradigm

According to Carr & Kemmis (1986) the purpose of interpretivism is the articulation of subjective meaning. The goal of interpretivism in Benner's (1994) view is:

> "...to discover meaning and to achieve understanding." (p60)

Schwandt (1994) does identify some tensions in interpretivism, hinging on the subjectivist/objective debate. He summarises it as:

> "They celebrate the permanence and priority of the real world of first-person, subjective experience. Yet, in true Cartesian fashion, they seek to disengage from that experience and objectify it." (p119)

These tensions are explored in the second section of this chapter and are largely related to understanding how phenomenological research achieves something more than subjective descriptions of an experience, but at the same time maintains a fidelity to lived experience.

Within the broad rubric of interpretivism there are several strands; ethnography, symbolic interactionism and ethnoscience, phenomenology. Although each strand has some distinct qualities, there are also considerable commonalties. However,

identifying differences between them is used as a heuristic device to explicate the choice of phenomenology to provide the most appropriate guidance for this research.

Morse and Field (1996) categorise phenomenology as working with 'meaning' research questions, exploring the essences of experience. In contrast, they link ethnography with 'descriptive' research questions that focus on beliefs and practices of certain groups. Symbolic interactionism is linked to 'process' questions, experience which changes over time. Verbal interaction and dialogue questions can be identified with the strategy of ethnomethodology.

Morse and Field (1996) used a hypothetical research question about "arrivals and departures: patterns of human attachment" to clarify further each of the strategies. Table 1 is an abridged version of one produced by Morse and Field distinguishing research strategies. The adequacy of their definition of phenomenology will be discussed later. The definition given could be argued to fall short of the complete purpose of phenomenology. However, the definition will be accepted as it stands at present for the purposes of differentiating interpretive strands.

In order to illustrate and expose the strategy guiding this research and demonstrate how several strategies are influential, Morse and Fields' schema is adapted in Table 2 to incorporate the questions posed in this research study.

Table 1 Strategy distinctions (abridged from Morse and Field 1996 : 29)

Strategy	***Focus***	***Types of results***
Ethnography	What is the arrival gate like when an international plane arrives ?	description of the day-to-day events at the arrival gate
Grounded theory (symbolic interactionism)	Coming home -- reuniting the family ?	description of the social psycho-logical processes
Ethnoscience	What are types of travellers?	taxonomy and description of types and characteristics of travellers
Phenomenology	What is the meaning of arriving home ?	in-depth reflective descriptions of the experience

Table 2 Applying Morse and Fields' schema to this research issue

Strategy	**Focus**	**Types of results**
Ethnography	What is community nursing like?	description of day-to-day culture of community nursing
Grounded theory	What is nursing and being nursed in the community like?	description of social psychological processes experienced in the community context
Ethnoscience	What types of community nurse are there?	taxonomy of characteristics of CHNs and students
Phenomenology	What is the meaning of nursing in the community context?	reflective descriptions of the experience as it is perceived by CHNs and sts

Each strategy is examined in more detail, concluding with phenomenology, the strategy chosen to direct this research.

Ethnography:

This strategy would lead the research to describe the day-to-day world of community nursing. It would access the different situations, relationships, encounters and activities undertaken by community nurses. The potential participants could be anyone who has a perspective on the world of community nursing. These people may have direct or indirect involvement.

Mackenzie (1992) reports an ethnographic study of district nurse students that aimed to gain understanding of their learning experiences. She describes the ethnographer as being:

> "...concerned with meaning and understanding, recognizing that individuals interpret situations and act in accordance with their interpretation and understanding of each situation." (p684)

This description has a great deal in common with phenomenology and serves to emphasise the commonalties between perspectives within the interpretive paradigm. However, a distinction can be identified when the detail of the research is examined. The accounts of the experience presented by Mackenzie include degrees of reflection and rationalisation. This is an issue that distinguishes ethnography from phenomenology.

This current study aims to access the meaning of the practice experiences for the CHNs and students concerned. It is the meaning of the experience, not a description or rationalisation of the content of the experience that is important but, as Crotty (1996) explains the purpose of phenomenology :

> "pursues not the sense people make of things, but what they are making sense of." (p3)

The ultimate aim is to contribute to the education process and it is therefore the meaning of the experience for the participants in the education process, the CHN and student that is important. Patients, carers, other participants' views are not being sought.

Symbolic interactionism / Grounded theory

According to Koch (1993) symbolic interactionism and grounded theory evolved from phenomenology. A succinct definition of this strand of the interpretive paradigm is provided by Van Manen (1990) as:

> "Symbolic interactionists understand social reality as a complex network of interacting persons, who symbolically interpret their acting in the social world.....human beings tend to act on the basis of how they believe other people behave towards them; and their self - perceptions and feelings tend to be mediated by how they think others see and feel about them." (p186)

This strategy is very closely linked to that chosen for this study and the distinction between a study guided by phenomenology rather than symbolic interactionism can at times appear tenuous.

A symbolic interactionist approach would question the experience of community nursing in respect to the social psychological processes involved. It would be based on how, for example, the student came to experience a certain version of community nursing, and what was it in that experience that led him/her to that perception. The interaction of the parties involved would be central. The relationship and the communication content and style between student and mentor would be important.

In this study I am concerned with what it means to practise and to learn to practise nursing in the community context. A communication process between learner and teacher is integral. However, the process of communicating learning is not the primary focus. At present we know such a limited amount of what there is to learn that addressing this issue is a logical preliminary to examining the process of education.

To summarise, symbolic interactionism/grounded theory does not access the level of meaning addressed in this study. Although the research has a comparative element, it is at the level of comparing the reported experience of both groups. Symbolic interactionism may be an appropriate strand of the interpretive paradigm to develop the research at a later date when the lived experience of nursing in the community context has been documented.

Ethnoscience

Again, this strand of the qualitative paradigm is relevant to this study, helping to direct some aspects of it. This study is set in and to some extent is driven by, a context in which the range and types of community nurses are being reviewed. The new nurse education process (UKCC 1986) has provided an environment for the development of the community staff nurse role. The opportunity for grade mix in the community nursing world has never been so ripe. As the research has a comparative route, juxtaposing the constructed meaning of students and CHNs, a taxonomy of the potential continuum of perspectives / understandings of community nursing is inevitable. However, the distinctions between the two groups (or indeed, within

groups i.e. the experienced versus the inexperienced CHN) is a means to access and make explicit the potential constructed meaning of practising nursing in the community context.

Phenomenology

My initial interest in phenomenology as a possible framework for this research was generated through a reading of the work of Benner (1984, 1994a,b,). However, when phenomenology was explored more closely, diverse interpretations of this perspective were revealed.

Van Manen (1990) describes phenomenology as a means of gaining a deeper understanding of everyday experiences. This notion appeared to fit well with the aims of this research. This can be explained more clearly with reference to curriculum content. The education curriculum devised to prepare nurses to practise in the community setting devotes considerable attention to social policy theory. Student knowledge of community care policy and legislation, primary health care organisation and funding is deemed to be very important. Indeed this knowledge is very relevant to the nurse who is practising in the community context. In the course of practising nursing, it may be possible to track a chain of events back to a Department of Health policy, but it may be a rather long and tenuous chain. The criticism levelled against this being the main thrust of the educational preparation for community nursing is that it provides an environmental description but does not address the depth of the contextual landscape. This knowledge does not totally

enlighten the learner about practising *nursing* in this *context* as opposed to other health care contexts.

Phenomenology emphasises the natural state and accounts of experience without conceptualisation or categorisation and therefore it will be the preferred methodology for the current study.

Phenomenology

Phenomenology only really made its appearance in the nursing research world in the 1970s. Its popularity as a means of researching nursing has developed considerably since the mid 1980s.

Phenomenology addresses taken-for-granted aspects of experience and explores their meaning. It is this philosophical basis that fits best to this research. Benner (1985) describes its aim as to:

> "...uncover meanings in everyday practice in such a way that they are not destroyed, distorted, decontextualised, trivialised or sentimentalised." (p6)

Darbyshire (1994a) uses Giorgi's (1975) work to summarise the essence of phenomenology :

> "The task of the researcher is to let the world of the describer, or more concretely, the situation as it exists for the subject, reveal itself through description...Thus it is the meaning of the situation as it exists for the subject that descriptions yield." (p190)

However, further exploration of the detail of phenomenology generates some debate arising from the diversity of interpretation offered in the literature. This is exemplified by Merleau-Ponty's (1967) comments cited by Morse (1991:25). In asking the question "What is phenomenology?" he stressed the continuing development of the definition:

> "it may seem strange that this question has still to be asked half a century after the works of Husserl. The fact remains that is has by no means been answered."

Taylor (1994) draws attention to the diversity within the perspective by referring to Spiegelberg (1976):

> "...there is no school of phenomenology representing a rigid, uniform view, rather it could more aptly be described as a 'movement'." (p40)

The history and current debates in phenomenology are discussed in more detail below in order to clarify the rationale guiding this study.

Definitions:

Review of the literature identifies a number of definitions of phenomenology. For example, Graham (1994:236) suggests that the phenomenological approach "enables the researcher to draw primarily upon the individual in a particular situation and utilises verbal and written data to guide explanation of a lived experience.". According to Wilkes (1991) phenomenology is "...an approach to viewing and researching lived-experience within a world." "A methodology which acknowledges and values the meanings people ascribe to their own existence is that of phenomenology" is the definition used by Taylor (1993). Alternatively, Keen (1975) defines it as "...the study of human experience from the actor's particular perspective.

The purpose of phenomenology is to more fully understand the structure and meaning of human experience." (quoted in Knaack 1984). Hallett (1995b:159) describes it as being concerned with "examining the ways in which human beings perceive their world". Core tenets are identified by Morse (1991) who distinguishes phenomenology as aiming to 'interpret and understand' as opposed to 'observe and explain.'

From this range of definitions, it could be argued that phenomenology has two core elements, experiential description and meaning. The focus of much of Crotty's criticism of nurse phenomenologists is that they limit their work to subjective description.

'Lived experience' is a frequently encountered phrase in phenomenological writing. It is therefore important to explore what is meant by this term and the significance it has for this research. Taylor (1994) declares that:

> "Lived experience is awareness of life without thinking about it, a pre-reflexive consciousness of life that, when remembered, gathers interpretive significance." (p56)

The sense we make of our lives is because of our lived experience which informs us about our impressions of our world. This concept of 'lived-experience' appears to fit well with the level of explanation aimed for in this study i.e. the experience of practice described in the participants own language, minimally structured by the researcher. It refers to a type of knowing nursing - 'awareness of life without thinking about it - of which we have very limited understanding.

At a general level, these definitions of phenomenology appear to describe an appropriate framework to guide this study. However, closer examination of the detail of the phenomenological perspective identifies a number of issues that require further elaboration.

Unravelling the strands

A central debate revolves around views on epistemological and ontological issues. These are commonly expressed in a comparison between the Husserlian and Heideggarian schools of phenomenology. Several other philosophers have also developed the perspective in different ways. For example, Schutz (1967) combined Husserlian phenomenology and Weberian sociology to develop what is termed phenomenology of the social world. His work was influential in Blumer's (1969) perspective of symbolic interactionism. Gadamer (1975), as student of Heidegger extended this phenomenological perspective emphasising language and the role it has in revealing being.

More recently nurse researchers have developed interpretations of phenomenology. For example Benner (1984) reports to be following an interpretation of phenomenology which was *shaped* by Heidegger and the existential perspective. The claim that Benner's theoretical framework is derived from the Heideggarian school is challenged by Crotty (1996) who suggests that the interpretation developed recently by some nurse researchers is:

> "...to a large extent ...diametrically opposed to his *(Heideggers)* intent and method." (p75)

I would take issue with Crotty's criticism because it is based on a comparison between Benner's framework with that proposed by Heidegger. I do not believe that Benner actually purports to have 'lifted' Heidegger's approach in its entirety. Indeed in the introduction to *'Interpretive Phenomenology'* (1994a) she writes that the book reflects:

> "...the work of a scholarly community who have worked out what interpretive phenomenology *has to offer nursing science..." [my italics]* (p xiii)

and that the writings are an:

> '...ongoing project of developing interpretive phenomenology."

These comments suggest that Benner is generating a strand of phenomenology which will assist with the exploration of nursing questions which has its roots in existentialist phenomenology but which is likely to develop into something different.

In the discussion which follows the major strands of phenomenology are identified and comparisons are made between them.

Husserl's phenomenology:

Husserl (1964) addresses the question of 'how do we know what we know?' and in doing this he questions the objectivist approach. The starting point of Husserl's philosophy is that subjective consciousness rather than the external world is the location of knowledge and understanding. Fjelland and Gjengedal (1994) provide a very clear explanation of this perspective. They address the concept of perceiving a building from an objectivist perspective and a Husserlian perspective. Significantly

the scientific or objectivist explanation starts with the object. The process begins with light rays reflected from the building reaching the retina, nerve impulses pass to the brain and the person sees the building. However Husserl challenges this rationale on the basis that an individual seeing a building does not experience it as being in the brain, but in the world. He questions whether objects exist independent of the person and in so doing challenges the dualism. Fjelland and Gjengedal use distance measurement as an example saying:

> "...perceived distances are subjective in the sense that they exist only in our consciousness and would disappear if we disappeared." (p15)

Husserl was concerned with the taken-for-granted experience of life which because of its very nature may not be very accessible. Koch (1995) describes it as aiming "to bring to light the ultimate structures of the consciousness."

The three notions of 'intentionality', 'essences' and 'reduction' are crucial to Husserlian phenomenology.

Intentionality "indicates the inseparable connectedness of the human being to the world" (van Manen 1990:181). When we think, we are thinking about something, and are oriented to something - but we are only retrospectively conscious of this orientation.

'Essences' are the core structures which are isolated in the phenomenological process. Van Manen (1990) explores the derivation of the word. Essence comes from the

Greek '*ousia*, (the inner essential nature of a thing):

> "Essence is that what makes a thing what is it and without which it would not be what it is." (p177)

The third notion of reductionism refers to a process of purification of consciousness in order to study ideas in their pure form. To this end, influenced by his mathematics background, Husserl developed 'bracketing'. Crotty (1996) clarifies this notion using the analogy of a metal being separated from non- metallic substances when it goes through a process of reduction.

'Reductionism' therefore relates to the disconnecting of assumptions and suspending beliefs. Followers of Husserl would therefore aim to produce a 'pure' description of the phenomenon in question, uninfluenced by their preconceptions which have been bracketed. In other words, an ahistorical approach.

'Bracketing' has been interpreted in a variety of ways. Crotty (1996) has suggested that many nurse phenomenologist purporting to follow Husserl actually misinterpret Husserl's notion of reductionism. He describes nurse phenomenologists as reporting to suspend their beliefs so that they do not interfere with the data generated by the research participants. However, he suggests that what they should be doing is assisting research participants to suspend their beliefs. He describes Husserl's intention as :

> "...moving from naive understanding of the object to the object itself, understood intuitively, as it presents to consciousness in an original and direct fashion." (p59)

Bracketing is therefore seen to relate to the respondents as well as the researcher. Husserl's perspective is also referred to as transcendental phenomenology. *The Oxford Dictionary* (1941) defines transcendental as "not based on experience". This reinforces the objective aim and is one of the main issues directing me to other strands of phenomenology.

Although reporting to be strongly influenced by Husserl, Hallett (1995b) also reports to deviate from his philosophy in relation to bracketing. She provides the following description of her approach:

> "I place more emphasis on the hermeneutic or interpretive element of the process than on the 'bracketing' which occurs. Indeed I view 'bracketing' in Oiler's terms, as a process which brings perspective (or prejudice) 'into view' rather than eliminating it." (160)

It is a similar sentiment, bringing perspectives 'into view' which directs me to Heideggarian phenomenology which supports the notion of historicality and allows the researcher to participate in the data generation and interpretation processes.

Heidegger's phenomenology:

Martin Heidegger was a pupil of Husserl and developed his own refinement of phenomenology. Darbyshire (1994a) makes a succinct distinction between Heidegger and Husserl suggesting that rather than the Husserlian question of 'what does it mean to know' Heidegger (1962) adopts a more fundamental perspective posing the question 'what does it mean to be?'

Heidegger took issue with the subject/object distinction to Husserl's version of phenomenology. He questioned Husserl's focus on 'how' people know and suggested it would be more appropriate to consider how people 'are'. Koch (1993) draws on the work of Dreyfus to further clarify the perspective :

> "Primarily, and in our most characteristic modes of being, we humans are not subjects, spectators, observers separated by an invisible plate-glass window from the world of objects in which we find ourselves. We are not detached from some external reality which is 'out there' trying to gain knowledge of it as something categorically different from ourselves, and trying to relate to it. (p100)

There appears to be similarities in this debate with the theory/practice debate in nursing, with suggestions for a symbiotic relationship being akin to Heidegger's perspective. This is one factor which draws me to this interpretation of phenomenology.

Heidegger contends that we can be engaged in the world without being conscious of the engagement. He gives an example of an expert carpenter who use the tools of his trade without thinking about it in a conscious way. The tool is 'transparent' to him. This argument rests on Heidegger's contention that:

> "people are primarily in and of the world, rather than subjects in a world of objects." (Reed 1994: 337)

In relation to this research CHNs practise in the community context, but are they actually aware of the phenomenon of community ? A core issue in Heidegger's argument is the notion of *dasein*. Several researchers (McLeod 1990, Reed 1994) draw on Heidegger's example of hammering to clarify the concept. Although a

carpenter may use a hammer it is not in a conscious way and indeed it may be 'transparent' to him/her and only articulated through the act of hammering. Reed (1994) describes three elements to dasein; attunement, articulation and 'for-the-sake-of'. Attunement refers to the way in which we meet an experience and is related to the past i.e. how we come to approach an experience. This concept appears to have commonalties with Schon's naming and framing notion. Articulation refers to the present state when "things are related to their functions". The third element, ''for-the-sake-of'' relates to the goal of the activity.

In order to consider how dasein has meaning for this current research study, the hammering example is explored further and alternative examples are developed. Firstly, hammering as a category of activity requires consideration. Hammering is very much a motor activity and in some ways may have factors in common with the technical, mechanical aspects of nursing practice. They may be transparent during the process of practice, especially when practice is successful. However, it could be argued that there are explicit feedback loops within the process i.e. if you hit your finger with the hammer. Similarly if a nurse uses a lifting aid awkwardly s/he and the patient experience discomfort, if the nurse experiences excessive resistance to skin entry when giving an injection, both the nurse and patient will be aware of this. These types of activities only describe one dimension of nursing practice. This dimension of practice is already apparent in one sense, we are aware of it and can categorise it. Transparency may exist in the process of these aspects of practice i.e. the nurse may experience difficulty in articulating what it is about appropriate injection technique - patient preparation, site selection, angle of entry which makes

for a successful procedure. It may only be when a negative event occurs that the nurse could back track and identify the issues responsible. What would probably be even more difficult is to track all the components of a successful procedure.

This study is concerned with practice experience in general, not critical incidents which stand apart from the 'normal'. It may therefore be more fruitful to consider the concept of dasein in relation to other dimensions of nursing which at present exist in a more 'transparent' state. For example, according to McIntosh (1996) :

> "...professional artistry has remained hidden." (p316)

One reason for this may be that the feedback loop for this aspect of practice may be less well developed than that of a motor activity, particularly in a learning in practice setting. The attunement, articulation and goal of these experiences are potentially more complex. This research study is however supporting their articulation through the act of nursing practice on the assumption that it is through the practice of nursing, rather than contemplation on the practice of nursing, we can become more aware of nursing itself.

Another issue in this discussion needs to be highlighted, the issue of reflection. One aspect of Husserl's phenomenology with which Heidegger takes issue is that of reflection. Husserl identified reflection as being instigated when something goes wrong or there is a problem. Heidegger classes this as second order reflection and it is occurring too late. In contrast Heidegger refers to a different level of reflection, a pre-reflective state, the state of being there.

In Heidegger's view humans are situated beings, it is therefore important not to divorce people from their context. This is endorsed in Heideggers phrase 'Being -in-the-world'. Benner quotes directly from Heidegger to further clarify the concept of dasein in terms of the significance of 'things' for individuals :

> "[Dasein] finds itself primarily and constantly in things, tending them, distressed by them, it always in some way or other rests in things. Each one of us is what he pursues and cares for. In everyday terms we understand ourselves and our existence by way of the activities we pursue and the things we take care of ."
> (Heidegger 1975:158 in Benner 1994:49)

Koch (1993) reports that according to Heidegger, meaning does not lie within the individual or within the situation but :

> "...is a transaction between the two so that the individual both constitutes and is constituted by the situation." (p101)

It is this understanding of our existence which is the focus of this study, how students and CHNs are situated in the world of community nursing and what the detail of their 'situatedness' tells us about this as a context for nursing practice. However, according to Heideggerian philosophy, our understanding of self :

> "...is not totally available to us. Our background meanings and pre-understandings, our interpretations of being-in-the-world are inaccessible to us, concealed through our everyday existence."
> (McLeod 1990:60)

If the detail of 'being situated' in the community setting can be made more available, this detail may then be used to enhance the education endeavour.

Within this strand of phenomenology are the two elements of historicality of understanding and the hermeneutic circle. Heidegger acknowledges that in every encounter there is an element of interpretation, with the individual drawing on their background understanding, only some of which can be made explicit. Meaning is not discovered but created, aided by the pre-understanding brought to the experience. The person is constructed by the world and the world is constructed by the person. From this evolves the hermeneutic circle where pre-understandings are modified in a circle process. This is at odds with Husserl's notion of bracketing. The circle notion is reminiscent of the experiential learning circle described earlier in Figure 5.

However, it may be argued that pre-understandings, responsible for the place at which each participant enters the hermeneutic circle are not clearly explicated. Someone may then enter the sense-making process but may not necessarily take the 'right' route to understanding. Making sense of the experience may therefore not reach its full potential. In order to develop this issue further I will use a transport analogy. It may be possible to get from A to B by train following a number of routes. Route *x* may be the quickest and least scenic, route *y* may call at every small station along the way and appear slow and repetitive, route *z* may be of interest to specific groups i.e. steam enthusiast. It is therefore important for the potential traveller to specify their needs before starting their journey to ensure they go to the correct platform. Although any train may get them to their desired destination, the process and outcome may not be as they desired. By taking train *x* a traveller may develop a very limited vision of the landscape.

Entering the hermeneutic circle or entering the learning process without due thought and awareness may have similar outcomes. This is a complex process complicated by the fact that the pre-understanding held by the participants may be transparent to them and taken for granted. Eisner's (1991) words are particularly pertinent :

> "...being situated in a state of affairs means essentially that the events will wash over us; we are often not particularly conscious of life as lived..." (p183)

Overall, a Heideggarian perspective focuses the research on experiencing and understanding rather than knowing and this fits well with the intention of this research study.

Hermeneutics

Van Manen (1990:179) describes hermeneutics as "...the theory and practice of interpretation." Dating from the 17th century, hermeneutics originally stood for the principles of biblical exegesis. In the 19th century Dilthey developed hermeneutics as the primary method of the humanities. The term now has a strong relationship with Heidegger (1962) and Gadamer (1975). Pascoe (1996) details the derivation of the term 'hermeneutics' from the Greek verb *hermeneuenen*, ('to interpret') and the noun *hermeneia*, ('interpretation').

Van Manen (1990) distinguishes the two components of hermeneutical phenomenology as :

> "...the descriptive study of lived experience (phenomena) in the attempt to enrich lived experience by mining its meaning; hermeneutics because it is the interpretive study of the expressions

> and objectifications (text) of lived experience in the attempt to determine the meaning embodied in them."(p38)

As with phenomenology, there are a number of interpretations of hermeneutics. Koch (1995) notes that in nursing literature, the terms 'hermeneutics' and 'phenomenology' are often used interchangeably without recourse to specifying the philosophical distinction. Benner (1994a) describes hermeneutics as a means of interpretation which allows the discovery of 'hidden or obscured meaning', meaning which is taken-for-granted. She states that Heidegger believes we do not see because of familiarity :

> "...we are so culturally and socially embedded in familiarity with our practices and skills that we lose sight of our being from existing within this familiarity." (p65)

In this study some of the participants could be assumed to be very familiar with their situation i.e. the CHNs. The other group, students could be assumed to have a lesser degree of familiarity, indeed they are meeting and developing new practices and skills. The key issue here is that for the purposes of clinical education we rely on giving students experience in practice alongside an experienced practitioner. If there is a risk that the experienced practitioner (CHNs) may ' lose sight of (their) being from existing within familiarity', does this situation actually fully alert students to 'being' . Heidegger's notion appears to have much in common with the comments made by de Groot (1965) referred to in Chapter 2:

> "...the more experience a person has collected in any field, the more difficult it becomes for him to understand the behaviour of have-nots" (quoted in Gale & Marsden 1983:2)

The comments made by Kenyon et al (1990) reported earlier suggest that they believe 'being' is significantly impacted by context. To follow Heidegger's assertion through, how do we make this 'being' more explicit in view of the potential for taken-for-grantedness. The inclusion of two groups of participants who may logically be thought of as being at different ends of the continuum of familiarity may help to access some of these issues.

Pascoe (1996) highlights the diversity in the development of the hermeneutic perspective :

> "...the tradition has undergone a complex evolution, with many internal divisions and differing assumptions." (p1310)

Interpretive phenomenology is one description of Heidegger's hermeneutics. Wilson and Hutchinson (1991) define it as interpretation of experience through a text. An important issue is Heidegger's notion that experience is veiled. It is by a process of 'unveiling' in collaboration with the research participants that allows us to see new ways of being. Wilson and Hutchinson used this interpretation as a framework for their research aimed at describing and interpreting participants meaning and practices of care giving.

In Gadamer's interpretation, he rejects the subject/object divisions and identified the 'fusion of horizons' as a means of achieving understanding within the hermeneutic circle. In essence 'parts' are interpreted from the 'whole' and the 'whole' from the

'parts' in a circular activity. Pascoe (1996) reports that the concept of understanding is central to Gadamer's perspective and understanding :

> "...occurs when the horizon of the scholar, intersects or fuses with the horizon, context or stand point of the object under enquiry. The vehicle which facilities this process is open and participatory dialogue." (p1311)

McLeod (1990) draws on Gadamer's interpretation principle of entering a dialogue with the text, a movement between hearing and questioning.

Van Manen (1990) describes hermeneutic phenomenology as being:

> "...a descriptive (phenomenological) methodology because it wants to be attentive to how things appear, it wants to let things speak for themselves; it is an interpretive (hermeneutic) methodology because it claims that there are no such things as uninterpreted phenomena." (p180)

He further explicates this phenomenological strand emphasising that it is concerned with 'pre-reflective' experience rather than conceptualised experience. Abstracting occurs after capturing the report of the lived experience by attempting to articulate the meaning structures that are 'embedded' in the experience. Accessing accounts of experience in their 'pre-reflective' state is one aspect of the perspective which has caused some concern for this research and this is discussed further later.

Nursing phenomenology

As mentioned earlier, Crotty (1996) has been highly critical of the interpretation of phenomenology used by some researchers, notably Benner, although he actually

reports a critique of 30 pieces of nursing research. He identifies a number of issues on which to cast doubt that 'mainstream' phenomenology is actually being used. He suggests that this newer form of phenomenology explores individual subjective perceptions of experience or sense-making. On the contrary the 'true' aim of phenomenology is to reach the phenomenon to which the individuals are giving meaning. This is different to the phenomenon which nurse researchers purport is established by synthesising the elements of experience. Part of the problem in Crotty's view is that nurse researchers stop at the level of describing perceptions of experience rather than progressing to the phenomenon reached through the experience. He quotes van Manen (1990):

> "From a phenomenological point of view we are not primarily interested in the subjective experiences of our so called subjects or informants, for the sake of being able to report on how something is seen from their particular point of view, perspective or vantage point. ... the deeper goal which is always the thrust of phenomenological research remains oriented to asking the question of what is the nature of this phenomenon as an essential human experience." (p34)

Fundamentally, Crotty calls into question notions of *Being* used by Heidegger and the 'new' phenomenologists. The latter aim to make 'life experience intelligible' whereas Heidegger "...is not dealing with real life issues and circumstances" but rather a "deeper level of intelligibility where the underlying structures of being are to be found." He accuses them of reporting subjective experience rather than the phenomenon experienced.

Paley (1998) develops the phrase 'misinterpretive phenomenology' . He suggests that within nursing phenomenological research both Husserlian and Heideggarian schools

are used :

> "...although both groups concentrate their research activity on the idea of 'lived experience' and in practice there is little to choose between the methods they adopt."(p817)

However, in Benner's defence she does not claim to be following Heideggarian phenomenology, only to be influenced by it. She describes the strand of phenomenology she employs as interpretive and defines it as illuminating :

> "...the world of the participants, articulating taken-for-granted meanings and practices, habits, skills and concerns." (1994:xviii)

Koch (1993) also takes issue with an aspect of Benner's research. Koch identifies Benner as practising outside the hermeneutic circle because the researcher endeavours to remain 'aloof' to the process. This therefore calls into issue a basic tenet of hermeneutic phenomenology. In contrast Koch places the researcher as a participant in the process.

Nurse researchers are not the only 'guilty' parties within the world of phenomenological researchers. Indeed van Manen (1997) presents a list of researchers from various fields who "shied away" from the philosophical debates and admitted that their primary interest was in phenomenology as a reflective method.

There are obviously multiple incongruencies within the phenomenological paradigm and new versions are being developed which challenge some of what Crotty defines as 'mainstream' phenomenology. The diversity and debate within the perspective is obviously a source of tension. I have accommodated these problems by detailed

reporting of the chronology of theoretical framework development with reference to the theorists guiding my interpretations of the paradigm.

Constructivism

A complementary interpretive perspective which was also used to guide the research was constructivism. As one aspect of interpretivist thinking, constructivism develops from philosophical debates over the foundation of knowledge. Lowenberg (1993) links constructivism with the hermeneutic perspective :

> "...hermeneutic perspective is increasingly incorporated within the broad range of interpretive approaches, in that reality is seen as consisting of buzzing chaos that must be interpreted cognitively, rather than as an objective reality waiting to be discovered. This view is also commonly labelled a constructionist or constructivist perspective." (p65)

Higgs and Titchen (1995) define the constructivist philosophy as being:

> "...concerned with how people individually make sense of their worlds and how they create personal systems of meaning that guide them through their lives." (p134)

Here each individual develops their own map of their reality. By accessing the subjective meaning of nursing in the community context, it may be possible to construct a number of maps; for example, a map of the constructions of community as a context of nursing practice; or a comparison of the maps used by CHNs and students to navigate their experience of practice.

Schwandt (1994) believes that interpretivists and constructivists "share a common intellectual heritage" and provides a discussion on a range of constructivist

approaches. He refers to Guba and Lincoln's (1989) work to identify six properties of constructions.

1. Constructions help us to make sense of our experience
2. The construction we develop depends upon 'the range or scope of information available to a constructor, and the constructor's sophistication in dealing with that information' .
3. Constructions are shared and collective constructions may be developed i.e. with respect to an agreed understanding within a group.
4. There is such a thing as a "malconstruction".
5. Judgements on malconstructions must make reference to the "paradigm out of which the constructor operates".
6. Constructions are challenged when new information conflicts or you cannot make sense of new information because of a sense of "a lack of intellectual sophistication." (p129)

There appears to be a close affinity between these properties and the issues raised in the discussion of factors influencing this research. For example, the relevance to learning in practice, articulation of the detail of practice, developing 'disciplined' constructions in relation to Bousefield's (1997) multiple value systems in nursing, and questioning whether nurses of different levels of experience or nurses practising in different contexts and specialisms operate from the same paradigm.

Developing the education theme, Schwandt's discussion of Eisner's (1991) 'educational connoisseurship' version of constructivism helps to focus the aims of the current research. Methodology in this perspective is:

> "...concerned with how inquirers develop an enhanced capacity to perceive the qualities that comprise the educational experience and, further, how they can develop the skills to render those perceptions

> in representational forms that portray, interpret, and appraise educational phenomena." (Schwandt 1994:129)

This illuminatory quality appears to have much in common with Eraut's (1994:57) suggestion that higher education establishments should develop their ability to enhance "the knowledge creation capabilities of individuals and professional communities." In relation to learning in the practice situation it may also offer some assistance in guarding against "having the experience, but missing the meaning" (T.S. Eliot).

Therefore, constructivism is used in this research to build an educational picture from the meanings of experience voiced by participants. The level of meaning articulation is guided by hermeneutical philosophy. This combination of perspectives to address the specific research issue is in line with Polit and Hunglers' view that:

> "Paradigms should be viewed as lenses that help us to sharpen our focus on the phenomenon of interest - not as blinders that limit our intellectual curiosity." (1997:16)

Combining interpretivist perspectives:

In her book '*Revisioning Phenomenology*', Munhall (1994) reports giving the following advice to a student seeking guidance on the process of phenomenological research. This gives a sense of the debates and dilemmas met during the decision process for this study:

> "Student: But what about the method ?
>
> Me [Munhall]: Phenomenology as a philosophical perspective is perhaps difficult to understand. However, there is no "method". "Bracketing" is not sacred, if even possible. Phenomenology is not ten transcribed

> interviews It is not extracting themes. It is an approach to understanding human beings, what happens to them and what meaning these events or experiences holds for them. Each quest for understanding should be guided by the unfolding of the material that speaks language pertinent to your research. It's as though you are on a path, and every time you finish something on that path it will help you to decide where to go next ..." (p28)

The lack of a blue-print for handling the research process was initially a cause for concern. Where are the landmarks in the research process? The concern was fuelled by van Manen's (1990:13) haunting remark that with phenomenological research you can 'listen in vain for a punch-line'. This research has the purpose of illuminating the meaning of practice, but as Pascoe (1996:1312) reminds us, Gadamer suggests that "...the process of understanding can never achieve finality...". This creates a tension with the other intention of the research, that of being able to 'say something' about how education may respond as a consequence of increased understanding of the experience of nursing in the community. Munhall (1994:292) refers to van Manen (1984) to provide a summary of the problem:

> "Phenomenology differs from almost every other science in that it attempts to gain insightful descriptions of the way we experience the world. So phenomenology does not offer us the possibility of effective theory with which we can now explain and/or control the world but rather it offers us the possibility of plausible insight which brings us in more direct contact with the world."

Although phenomenology may be appropriate for guiding the level of understanding, constructivism, was seen as providing the framework to address the education focused intent of the research.

Summary : Section I

There are a number of perspectives within the interpretive paradigm which provide guidance for this study. However, this research specifically intends to focus on making meaning more transparent and is therefore directed to phenomenology. This is a complex, multiple stranded philosophy. It has been interpreted in a number of ways which has led to debates about researchers faithfulness to the philosophy (Koch 1993, 1995, Benner 1994a, Hallett 1995a,b, Crotty 1996, Paley 1998). A thorough review of the alternatives has therefore been presented to clarify the theoretical framework selected for this research.

After attempting to unravel the tenets of each strand, hermeneutic phenomenology, supported by constructivism appear to be compatible philosophies to both direct the research and to make sense of the data. Hermeneutics identifies the type of meaning sought and constructivism assists in achieving the phenomenological aim of identifying commonalties in the data.

The next section focuses on how these strands were interpreted for this research study.

Section II

Theoretical framework decisions

In this section the specifics of this study are identified and clarified by drawing on the hermeneutic and constructivist perspectives. The discussion then develops to chronologically explore how these strands of the interpretive perspective guided the research.

Fundamental to the study is the understanding that individual experience is made up of meaningful activities. These meanings set the parameters for our existence. Benner, Tanner and Chesla (1996) refer to the concept of being 'situated' in the world, where individuals have differing lenses on their experience or existence. A quote from Benner, Tanner and Chesla (1996) further explains the concept:

> "...one has situated possibilities, certain ways of seeing and responding that present themselves to the individual in certain situations, and certain ways of seeing and responding that are not available to individuals." (p352)

In relation to this study it is assumed that the community context of practice may generate specific sets of issues. It may be that nurses educated to different levels or with different levels of experience will engage in and experience the world in differing ways.

A tenet of phenomenology is that the world is not waiting to be discovered, but that meanings are constructed. The constructivist perspective therefore also contributes to the rationale of this study. Experience is a core concept in constructivism. Tinkler

(1993) explains :

> "To talk of sensations and percepts is to talk again about experience, for it is from experience that the mind generates percepts, and from those percepts, categories, constructs and concepts." (p136)

His discussion on novice and expert task perception is also relevant to this study, particularly to the CHN/student pairing - a senior student with a specialist practitioner.

Additional support for this framework also came from other researchers addressing questions at a similar level and who had successfully used phenomenology and specifically hermeneutics. I will discuss four examples, each of which contributes a different dimension to my understanding.

Phenomenology and specifically hermeneutics provided the framework for McLeod's (1990) research with experienced ward sisters. She sought to uncover the nature of everyday experience in nursing and its contribution to the development of expertise, something which is normally hidden. McLeod required a framework which would allow her to 'capture the complexity of nursing practice'. Although following a Heideggarian perspective she accessed a range of practice reflections - situations where the sister felt she had made a difference to the patient, a situation that went unusually well, situations that were ordinary or typical. Specifically she drew on the hermeneutic circle to guide the research which demanded a flexible plan of study. Through interpretation she sought something new, not the participants' interpretation or the researchers interpretation, but going beyond that to bringing them to light in a

new way. She posed questions such as 'what is the nature of knowing' in a given situation and how does it demonstrate itself ? Such questions are very relevant to this study of what it means to understand or experience nursing in a community context from different practitioner perspectives. The focus of this present study is the Heideggarian concept of 'being' or understanding rather than the notion of knowing.

Darbyshire's (1994a) account of his struggles within the interpretive paradigm and his grappling for understanding was useful in developing my understanding. His research explored the lived experience of parents of hospitalised children. He drew on the work of Benner and Heideggarian hermeneutics to explore how nurses and parents encountered situations. Darbyshire attempted to combine two strands of the interpretive paradigm, phenomenology and grounded theory. However, it was only when he experienced conflict during the analysis process that he realised that this combination would not work. Specifically he reports that following grounded theory forced him to think in a reductionist manner and did not allow him to dwell in a circulatory fashion on the participants' stories in order to uncover the lived experience.

Tina Koch's (1993) thesis was also particularly useful but in a different way. Her research focused on uncovering older patients' experiences of being hospitalised in which she sought commonalties in experience to "illuminate the common world". Koch provides a detailed and enlightening compare and contrast discussion of Husserlian and Heideggarian phenomenologies. She drew on Heidegger and Gadamer to guide her research. Her rationale for doing so was to avoid Cartesian

dualism in favour of the ontological question of what it is to be a person. Husserl's interpretation was rejected because she wanted to avoid reductionism and seeking essences, but to be allowed to participate in the research herself.

Hallett's (1995a,b) work has been informative in a number of ways. First, it relates to community nursing, although addresses a different issue - students' and supervisors' ideas about learning. Secondly, she also draws on a phenomenological perspective to direct the research. Thirdly, she uses elements of different strands of the interpretive perspective to address her particular research question:

> "Phenomenology as a research method is concerned with examining the ways in which human beings perceive the world. As a method for studying individual and subjective perceptions rather than absolute, objective 'truth', phenomenology must be moulded to the nature of the phenomenon under study." (p159)

Hallett's term 'moulding' had a liberating impact on the development of this research design. She draws on both Husserl's and Gadamers' interpretations of phenomenology at different phases of her research to allow her to answer her research question. Prior to reading her work, attempting to adhere to the restrictions of one interpretive strand was cause for some concern, since I felt a sense that the research was being fitted into a paradigm rather than paradigm knowledge being used to assist the exploration of the research question. However, I continue to have some unease in accommodating to a combination of Husserlian phenomenology (devoid of bracketing) and hermeneutical phenomenology.

The chronology of theoretical framework decisions

In this study a broad commitment to phenomenology was initially identified, and specifically the hermeneutic interpretation gradually identified as appropriate to the research. The research therefore has a descriptive and a meaning search remit. The research sets out to facilitate CHNs and students to describe their experience of their life world. These taken for granted experiences are then 'mined' (McLeod 1990) to identify meaning.

A minimalist approach to methodological discussion in research reports is a criticism made by Darbyshire (1994b). He says :

> Accounts of published research tend to perpetuate the view that a particular method is selected at the outset and that this method is simply "used" unproblematically and unchanged throughout the study." (p186)

Noting this criticism and in order to add to methodological debate I have chronicled the theoretical framework development of this research study.

Pre-reflective descriptions

One issue that required detailed consideration was Heidegger's notion of pre-reflective description. This is a difficult notion to appreciate especially as Heidegger also contends that people are self interpreting and that every description is in fact an interpretation. Achieving a pre-reflective level of data initially appeared to be a virtually impossible task. Heidegger claims that reflecting when something goes wrong or on a critical incident is second order reflection. The message I took for the

research was that I should be focused on the everyday experience, not on the unusual or something that has stood out for the participants as being different.

Van Manen (1990), also acknowledges difficulty with the pre-reflective notion and suggests that as experience is temporal, an immediate manifestation cannot actually be grasped. Experience can only be accessed 'reflectively as past presence'. Adhering to this aspect of the perspective presented me with a dilemma. Gradually an appreciation of the notion became clearer. The material for interpretation or meaning development should ideally be taken for granted accounts of practice, not practice which has been reflected upon or which has gone through some process of reflection by being identified by the participant as critical or different. It was then possible to accept entering into dialogue with oneself and with the research participants as a characteristic of phenomenology. Pre-reflective data provides the basis for meaning exploration guided by the hermeneutic circle. In order to uncover the meaning of these experiences, varying levels of reflective activity took place in line with Van Manen (1990) :

> "Phenomenology is, on the one hand, description of the lived- through quality of lived experience, and on the other hand description of meaning of the expressions of lived experience." (p25)

Operationalising the pre-reflective notion is debated further in the discussion on research design.

Levels of meaning

The limits of the overall process also required clarification. Criticism has been directed towards nurse researchers who are seen as stopping short of searching for

the meaning of the phenomenon under scrutiny and merely accessing the subjective meaning experience of the individuals concerned. Taylor (1995) draws attention to this distinction in describing the process of her own research :

> "At this point, I realised that these aspects illuminated the phenomenon, but they did not manifest the nature of the phenomenon itself. It is the prime intention of phenomenological methods to find the nature of 'the thing itself'." (p75)

Although highlighting this distinction, Taylor only reports that further interpretation took place. Greater detail of the process of transition would have been useful.

Anderson (1991) identifies that a discipline can be understood at two levels; one is a mapping exercise the other involves exploration of the land. The level of meaning aimed for and accessed is discussed in more detail in the 'Design and Methods' and 'Meanings and Interpretation' chapters. However, Chenitz and Swanson's (1984:213) reference to Rubin (1981) aptly identifies the research task :

> "We bring to the surface the latent meanings that lie outside the immediate awareness of the person who speaks them. And it is our task too to develop some system of ordering those words into the conceptual frame that permits broader and deeper understanding than already exists."

Surfacing meaning

How to carry out the task is the next question. How can latent meaning be brought to the surface. Rubin's sentiments have much in common with Eisner's concept of episemic seeing :

> "We not only know more than we can tell, as Polanyi (1967) has said, we tell far less than we know. Our knowing does not depend on our telling. Our telling is a way of making public what we have come to

> know. Connoisseurship is the means through which we come to know the complexities, nuances and subtleties of aspects of the world in which we have a special interest." (p68)

Hermeneutic phenomenology is the interpretive strand which philosophically matches this desire to uncover the taken for granted aspects of experience. Van Manen's (1990) discussion on researching lived experience has been used extensively in guiding the research process. Van Manen quotes Sartre's analysis of 'The Look' to explicate a phenomenological description. It rests on achieving a certain mode of awareness. Sartre's example describes the detail of someone becoming aware that they are being observed spying through a key hole. The change this creates for the person is akin to the process aimed for in this research :

> "Where moments before my mode was of being governed by unreflective consciousness, now 'I see myself because *somebody* sees me." (p 24)

Transferring the quotation to this research means accessing the familiar, unreflective lived experience of the participants and dialoguing with them to achieve another state of awareness, a level not normally experienced.

Finding concealed meaning

Bartjes (1991) describes hermeneutics as interpreting the concealed meaning in the phenomenon. In view of the implicit nature of much of practice theory, this is a particularly pertinent issue for this research. As the research progressed, the notion of concealed meaning became crucial. In the early part of the research CHNs reported that students "did not see all the layers of practice". However, they experienced difficulty in articulating the detail. In one way they were saying that something was

apparent - the layers students did not see. On the other hand the detail of the phrase 'layers of practice' appeared to be concealed from the CHNs voicing it. Plager's (1994) reference to Heidegger's notion of familiarity :

> "...we are so culturally and socially embedded in familiarity with our practise and skills that we lose sight of our being from existing within this familiarity." (p65)

was useful in trying to understand the difficulty reported by the research participants. I explained the difficulty in terms of the CHNs having lost sight of their 'being' in terms of nursing in a community context. 'Being' therefore had to be excavated. This notion of uncovering something hidden also has commonalties with Schon's (1992) discussion on professional knowledge and practice epistemologies :

> "Often, we cannot say what we know. When we try to describe it, we find ourselves at a loss, or we produce descriptions that are obviously inappropriate. Our knowing is ordinarily tacit, implicit in our patterns of action and in our feel for the stuff with which we are dealing. It seems right to say that our knowing is in our action." (p56)

Uncovering hidden meaning was therefore not an easy challenge. Three strategies assisted in progressing with the endeavour: adhering more closely to the pre-reflective state, employing CHN:student comparisons as a vehicle for discussion, and entering into dialogue.

Both myself and the respondents experienced frustration at some aspects of meaning appearing to be inaccessible. This is a typical comment:

> "There are things I could talk about, differences between me and the student, but I can't describe any in detail now...you would have to be there." [chnfg2]

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chnfg = community health nurse focus group

I interpreted these comments as a signal to get closer to the lived experience of the participants, not only physically but also theoretically. Van Manen (1990) describes phenomenology as aiming to renew our contact with experience. He further explicates this aspect of the perspective with reference to Merleau-Ponty (1962) who uses the terms 'reawakening' and 'relearning' experiences. Consequently the phenomenological researcher must :

> "stand in the fullness of life, in the midst of the world of living relations and shared situations. On the other hand it means that the researcher actively explores the category of lived experience in all its modalities and aspects." (p32)

Subsequent phases of the research moved data collection closer to concurrent with practice. The impact of this was to also reduce the amount of reflection taking place between experience and discussion, achieving something nearer a pre-reflective state in the initial experience account.

"Getting nearer" also has a physical connotation. The context of their lived experience, the community setting and patients homes raised some potential difficulties for both the researcher and the participants and these are addressed in detail in the research design discussion.

Fusing horizons

Further progress was made in mining the meaning by referring to Gadamer's notions of dialogue, fusion of horizons and the hermeneutic circle.

According to Koch (1993) :

> "Gadamer defines horizon as the range of vision that includes everything that can be seen from a particular vantage point." (p107)

There were at least three vantage points in this research; the researcher, the CHNs and the students. Greater use was made of them in a number of ways. Not only did it appear that Gadamer's 'fusion of horizon' concept was relevant to myself and participants, it was also relevant to the two groups of participants. The comparative element to the research was therefore seen as a strategy to access a deeper level of meaning rather than actually making a qualitative comparison between students and CHNs.

Juxtaposing CHN and student accounts of their lived experience was an important strategy in assisting the 'uncovering' of hidden meaning or meaning that was not readily accessible to the individual. There were degrees of consonance and dissonance in the accounts of CHNs and students on their experience of practice. The discrepancy between students and CHNs was understood with reference to Schon (1992):

> "When a practitioner sets a problem, he chooses what he will treat as the 'things' of the situation. He decides what he will attend to and what he will ignore. He names the objects of his attention and frames them in an appreciative context which sets a direction for future." (p53)

There was no intention of verifying which party was right or wrong, indeed this is incidental to the phenomenological focus. The point was to further explicate their

experience of practice in order to better understand the meaning of the phenomenon of community as a context for nursing practice.

In conjunction with horizon fusing, dialogue was also used to further the research endeavour. Accessing data nearer the pre-reflective level was complemented by working with the accounts using other strategies to actively explore the meanings of the experience. This latter activity is driven by hermeneutical phenomenology's goal to achieve something deeper than description. This means that the research was not just about gaining subjective descriptions of participants' experience of nursing in the community context. It was also about another level of exploration aimed at asking: "So what does this description of experience tell us about nursing in the community context ?" " How is this nursing in the community context ?" This additional and more complex level may equate with Crotty's criticism that some nurse phenomenologists fail to wholly honour the philosophy of phenomenology. Van Manen (1990) summarises the endeavour saying :

> "When a phenomenologist asks for the essence of a phenomenon - a lived experience - then the phenomenological inquiry is not unlike an artistic endeavour, a creative attempt to somehow capture a certain phenomenon of life in a linguistic description that is both holistic and analytical, evocative and precise, unique and universal, powerful and sensitive." (p39)

Engaging in something more than subjective description of lived experience, yet avoiding "disengaging from that experience and objectifying it" as described by Schwandt 1994 earlier in this chapter demands further exploration . In his paper *'Farewell to criteriology"* Schwandt (1996:64) clarifies that the task is not to "replace" the practitioners version with an "...allegedly more sophisticated,

theoretical...” version. Rather the task is about “improving a particular practice by reflecting on the values of that practice.” In order to meet this requirement the research participants, more specifically the CHNs, were involved not only in describing their experiences, but also mining the meaning in these descriptions. I therefore engaged in several phases of interpretation in this research. This gradually led not to an objectifying of the lived experience, but to more clearly articulate the phenomenon of nursing in the community context.

Interacting with the data

My role in interacting with the data requires clarification. The perspective taken very much followed Heideggers notion of co-constituent with the researcher participating in making the data and mining the meaning .

Let me firstly return to the issue of ‘familiarity’, from the researcher’s personal perspective. In view of my background as a former community nurse and current teacher of nurses, the discussion by Ray (1985) is particularly helpful in terms of what is informing and potentially influencing the study. She describes phenomenological theory as an integration of the participants’ description of their experience, the researcher’s intuitive grasp of the whole experience, the researcher’s accumulated knowledge and the researcher’s creativity in the organisation and explication of the phenomenon. The aim of this study is to access and describe what is meaningful to the participants.

The researcher is however acknowledged as part of the research process. This is conceived as the researcher acknowledging past experiences and available literature

which assist with exploring and explaining the phenomenon of community as a context of nursing practice. The purpose of this is to enable the researcher to work with the participants in an interactive manner to facilitate articulation of images or understandings of community nursing from which meaning can be built. While endeavouring to make my assumptions and values explicit in reporting the interpretation process, my stance is significantly influenced by Gadamer's 'fusion of horizons' concept.

Summary : theoretical framework

The study is guided by an interpretive paradigm, specifically hermeneutic phenomenology and constructivism.

As the research progressed the meaning of pre-reflective data became clearer. Initial resistance to accessing taken-for-granted meanings was addressed with reference to Gadamer's notions of dialogue and fusion of horizons. Participants and researcher were seen as interpreting within the hermeneutic circle acknowledging the role of fore-understanding. This involved a movement from the parts to the whole with modifications to understanding taking place in a cyclical activity .

While phenomenology guided the level of meaning accessed by the research process, constructivism contributed to the framework for making sense of the data about the lived experience of community nursing from a practice and educational perspective.

CHAPTER 4

RESEARCH DESIGN

&

METHODS

Introduction

As discussed in the previous chapter, this research is predominately guided by hermeneutic phenomenology and constructivism. This chapter discusses how these philosophies are translated into research design and strategies.

According to Van Manen (1990) :

> "The point of phenomenological research is to 'borrow' other people's experiences and reflections on their experiences in order to better be able to come to an understanding of the deeper meaning or significance of an aspect of human experience in the context of the whole human experience " (p62)

This sets the scene for the type of data the research was designed to access.

The research was initially designed to have multiple phases, although the exact features of the phases were developed as the research progressed. Simple aggregation of data was not the purpose of the different phases of the research. Rather, these were developed to capture different accounts of the lived experience of the participants' world of practising nursing in the community context.

Munhall (1994) provides some guidance on operationalising the phenomenological method :

> "Phenomenology is not ten transcribed interviews. It is not extracting themes. It is an approach to understanding human beings, what happens to them and what meaning these events or experiences holds for them. Each quest for understanding should be guided by the unfolding of the material that speaks language pertinent to your research. It's as though you are on a path, and every time you finish something on that path it will help you to decide where to go next..." (p28)

In keeping with the lived-experience philosophy of this research, I will use the first person to recount my research experiences.

In line with Munhall's description, Omery (1983) suggests that as phenomenological method is data driven, it can only emerge as the research progresses. This research design did undergo a series of transformations in response to the process which are discussed in this chapter.

Attempts were made throughout to stress the partnership relationship in this research process. The participants were invited to share in the development of the research design and interpretation throughout the process. The research was intended to achieve a hermeneutic level of data gathering and reflection with the participants.

Green and Holloway (1997) suggest that there is a deficit in phenomenological methodology knowledge. They criticise many research reports for only presenting a general discussion of the process rather than a detailed review of methods. Therefore, in order to increase the auditability of the research and to contribute to methodology debates, detailed discussion on method is presented in this chapter and discussion of analysis is presented in the following chapter.

Another factor driving the multiple - phase design was research credibility considerations. Denzin (1989) identified triangulation as one means of enhancing research credibility. Data source and method triangulation were therefore incorporated into the design. Member checking was also utilised by providing regular feedback to the participants as the research progressed.

Overview of data collection strategies

Figure 9 provides an overview of the strategies employed in this study. Although a student sample was not included in each phase, the student/CHN comparison was a theme of discussion in every phase of the study.

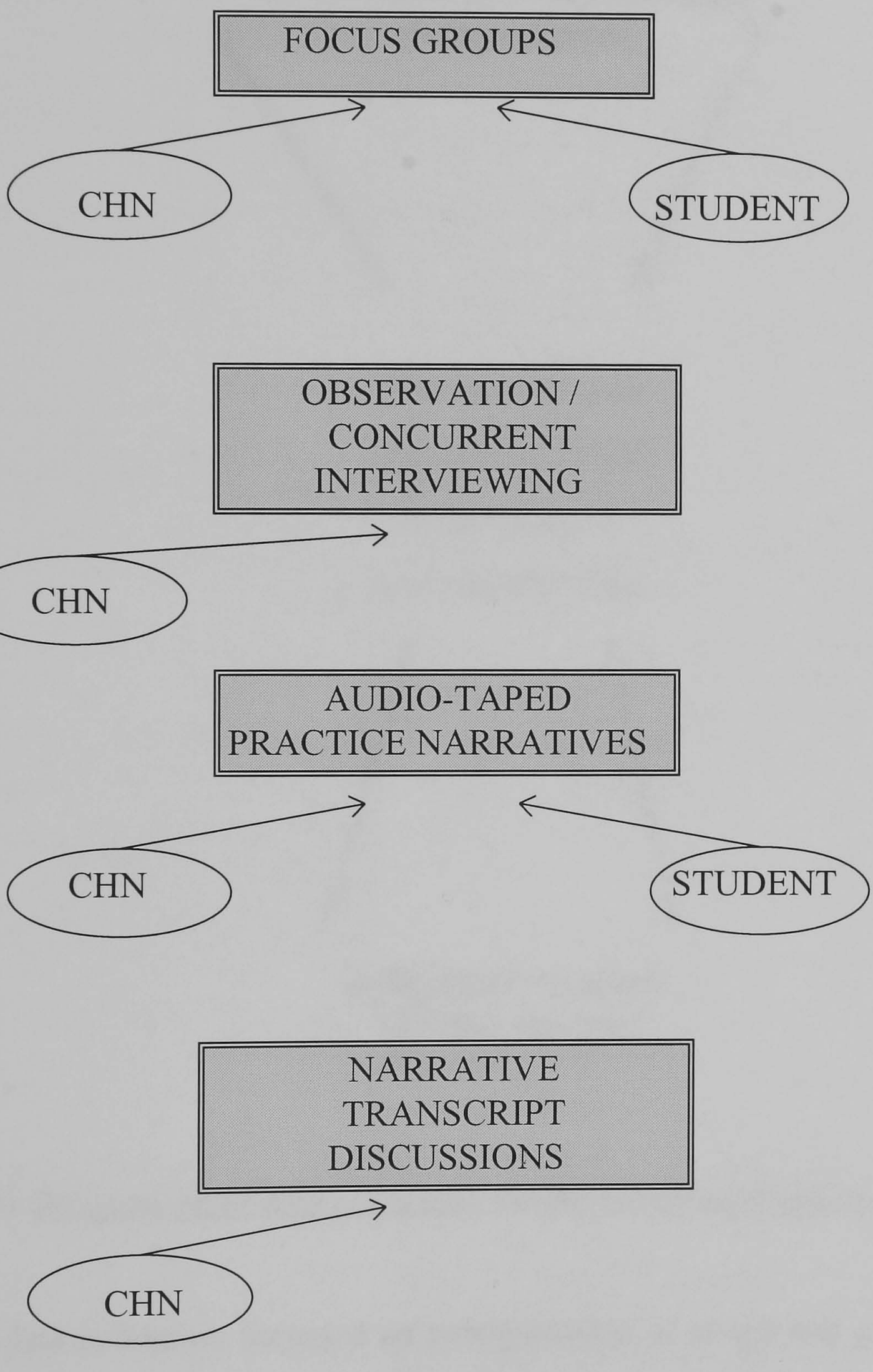

Figure 9 Overview of research strategies

The methods can be thought of as starting from reflection on practice, moving to near concurrent with practice and then reflections on actual practice episodes. This progression is summarised in Figure 10 .

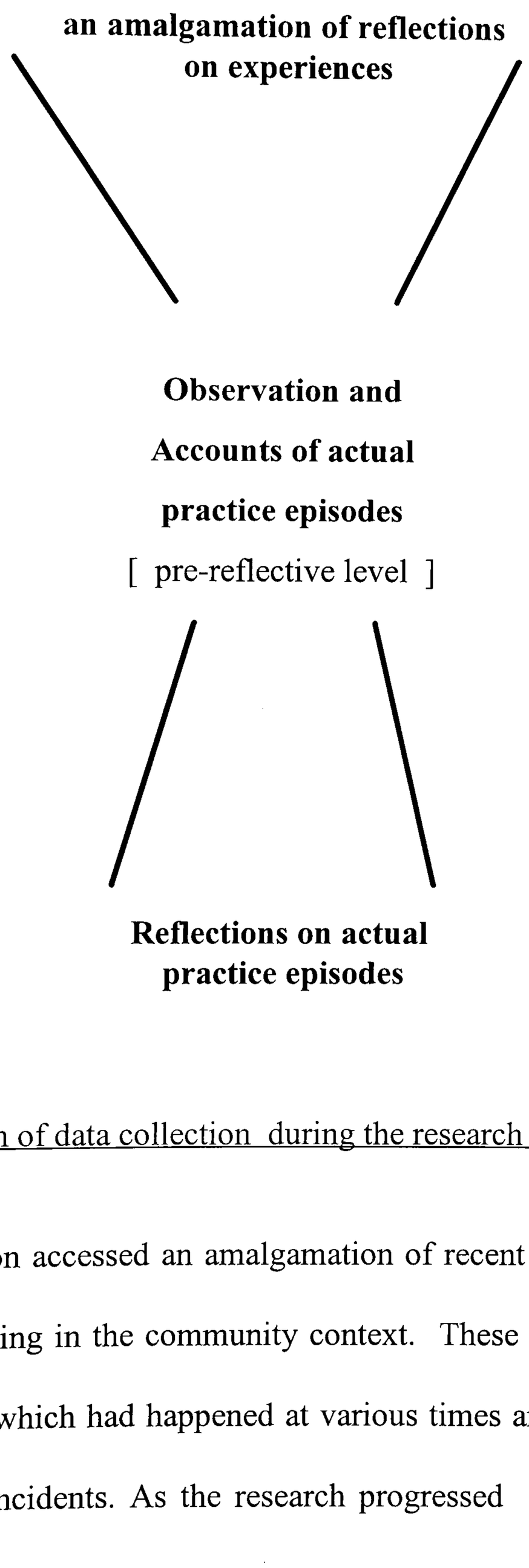

Figure 10 Progression of data collection during the research process

Initially, data collection accessed an amalgamation of recent and past perceptions of the experience of nursing in the community context. These accounts were therefore based on experiences which had happened at various times and therefore related to a 'collage' of practice incidents. As the research progressed the experience reported

was much more immediate and specific - more closely following Heidegger's pre-reflective level. For example, narrative accounts of a home visit which had just taken place were recorded. The data collection then broadened again during narrative discussions to allow meaning exploration of these specific experiences as well as related experiences identified by the participants.

The development, implementation and evaluation of each strategy employed in the research is discussed in detail in the following sections of this chapter.

Demands on research design

While cognisant of Silverman's (1993) comments that "field research should be theoretically driven rather than determined by technical considerations", the research design had to accommodate several pragmatic issues including :

- location of research participants
- participants time constraints
- a number of potential tensions.

Some of these issues were briefly referred to earlier where it was highlighted that limited research has taken place in the community practice context and that few previous design reports are available for guidance. The majority of research has taken place in the hospital setting where multiple participants can potentially be accessed at the same time. The researcher can take on a fairly unobtrusive role within the hospital ward. In contrast, in the community setting the researcher is a much more obvious

addition to the environment. The context of practice is the patient's home, this immediately places restrictions on the strategy and equipment used to collect data. The range of issues to be considered are listed below:

- the CHN population are a mobile and disparate population. Adhering to the phenomenological perspective, the study is to be rooted in practice and at least in part, pre-reflective practice descriptions. Practice is episodic, moving from clinics, surgeries, patients homes. The logistics of accessing participants can be quite complex.
- Practitioners generally work alone, therefore only one practitioner can be accessed at any one time.
- Time efficiency for research participants is a prime consideration. Today's health service is tightly costed and managers' agreements to allow staff to participate will be time constrained. CHNs dominant role is that of nurse. They already have to accommodate to the additional role of mentor/teacher to pre-registration students. Due to the developments in pre-registration nurse education discussed earlier, this element of their work has mushroomed recently. It would therefore be imprudent to develop a research design that was excessively demanding of their time.
- The CHN specialism is currently being challenged i.e. in terms of skill mix significantly fuelled by the emergence of the new Project 2000 practitioner. It is therefore important that participants are assured of the meaning construction focus rather than any evaluative focus with potential skill mix ramifications.
- The identity of the researcher as a former community nurse, now a nurse lecturer, must be acknowledged for a number of reasons. This background provides a type

of 'insider' status to both CHN and student worlds (Reed and Procter 1995). Credibility with CHNs may be enhanced and their willingness to participate consequently improved. However, on the assumption of mutual understanding of the world, there is a risk of participant/researcher dialogue skimming issues that an outsider may identify or be assumed not to know. In phenomenological terms this may inhibit accessing the detail of their experience i.e. both parties may be experiencing transparency of experience.

Similarly, the student population may struggle with the lecturer / researcher roles, i.e. have concerns that their views/ perceptions will be assessed. Several strategies were employed to accommodate these issues and they will be discussed as the chapter progresses.

Sampling strategies : selecting research participants

Skodol Wilson and Hutchinson (1991) describe sampling in hermeneutic research as 'purposive', choosing informants who :

> "... can provide rich descriptions of the experiences under study. Informants must be able to articulate their experiences and be willing to give complete and sensitive accounts" (p269)

The prospect of identifying those people who would provide rich descriptions, cognisant of the previously discussed potential problems with accessing practice knowledge/perceptions was very inviting. Initially, it was intended that one function of the first phase (the focus groups) would be to filter such informants. However, further consideration of the philosophical and practical issues negated this decision. Darbyshire (1994a) also decided to reject this notion in his phenomenological

research and it is his sentiments that I was drawn to follow. He considered that the key informant supposition was contrary to an exploratory study and to the tenets of phenomenology. All experience is significant to the individual experiencing it and it is that significance that creates their 'being-in-the world'. I wanted to get a picture of a range of practice/education constructions i.e. the lived experience of practising and learning to practise nursing as it actually occurs.

The selection of participants had to take place in multiple stages as the research progressed and methods changed. Initially, there were two stages to selection, detailed below :

- negotiation of access to participants i.e. CHNs and students
  - College of Health Studies
  - Community Trusts
  - Ethics Committees
- identification of CHNs and students who were willing to participate in the research

Negotiating access

College of Health Studies

A formal application had to be made to the research committee detailing the nature of the research and what student participation would involve. Permission to proceed with the research was granted.

Community Trusts

The educational institution places students in five different community trusts. Three trusts were selected for reasons of the researcher's familiarity with the management structure which had implications for gate-keeping to the sample.

A written approach was made to the Director of Nursing / Research Nurse Leader, (depending on the Trust protocol) at each Trust. Verbal presentations were subsequently requested. These were duly conducted and resulted in permission to proceed from all three Trusts. By this time it became clear to me that two trusts would potentially provide sufficient participants. The initial decision to seek permission from three trusts was influenced by anticipatory concern about response from trusts to a further demand on staff time, rather than anxiety over lack of support of the research question.

The 'negotiating access' stage of the sampling process is detailed in Figure 11. The selection of localities within the Trusts was at a pragmatic level, i.e. those managers who responded most promptly to my request.

Ethics Committees

The two District research ethics committees relevant to each trust were then approached and permission granted for the research to proceed.

The educational institution places students in 5 different trusts, although educationally the experience provided was considered to be equitable

Three trusts were selected for reasons of familiarity with management structure which had implications for gate-keeping to the sample

Written approach made to Directors of Nursing at each trust [1,2,3]

Invited to give verbal presentation on research plans

↓

OUTCOME

1. Enthusiastic approval and permission granted to use as research site	2. As 1.	3. Process of discussion was delayed due to organisational issues - permission granted, but considerable time delay compared to 1. & 2.

Decision made that using all three would be excessive,
therefore decision made to proceed with 1. & 2.,
but to keep 3. informed of the research incase appropriate to use
at later phase of the research

↓

Each Trust is divided into localities /geographical areas -
managers from 2 localities in each trust approached-
all managers supportive of the research

Figure 11 Sampling process / negotiating access to Trust staff

Individual research participants:

Students

The community placement in the branch programme was in the last semester of the programme. Student cohorts therefore changed as students passed through and left the programme. Participation negotiation therefore took place with each cohort as the research progressed through different phases.

It was decided that the student participants should be currently experiencing their community placement during their branch programme. Four student cohorts (10-15 students per cohort) were approached by the researcher at the beginning of the appropriate semester and given verbal and written information about the research. This is detailed in Appendix 1.

Great care was taken to ensure that as the researcher was also a lecturer in their learning establishment, no sense of pressure or coercion was experienced. Students met the request with varying levels of enthusiasm but the majority agreed to participate in the focus groups at the end of their clinical placement.

Each phase of the research required participation negotiation to take place with the current student cohort.

CHNs

The CHNs had to have experience of mentoring a pre-registration student nurse and/or be currently involved in this activity. The sampling process is detailed in Figure 12.

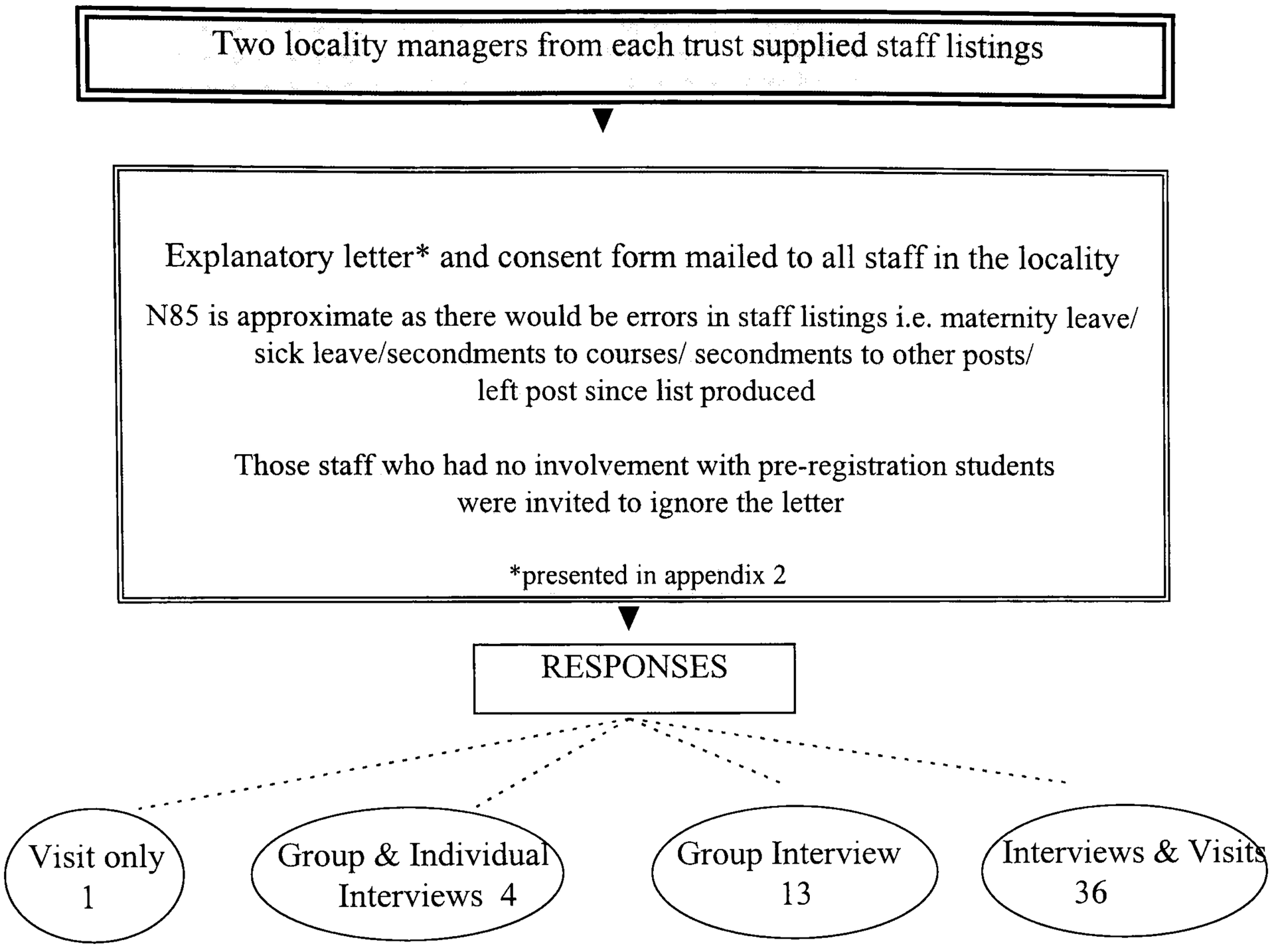

Figure 12 Trust staff sampling process

Sampling for other phases of the research was from within this sample group, but purposive. As a result of the longitudinal nature of the research, consent had to be negotiated on a continuing basis in line with what Morse (1991) terms 'process consent' . A deciding factor for inclusion in the subsequent phases was whether or not the CHN had a student nurse allocated to him/her at that time.

CHNs participating in the study therefore came from a variety of geographical and social locations and had varying amounts of experience practising nursing in the community context.

PHASE I

FOCUS GROUPS

This first phase of the research was exploratory and inductive, concerned with accessing multiple descriptions and understandings of the phenomenon of community as a context for nursing practice. Focus group interviews were the method of data collection in this phase. They are described by Morgan (1988) as an:

> interaction within the group, based on topics that are supplied by the researcher..." (p9)

Focus groups development

Nyamathi and Shuler (1990) suggest that focus groups can be used for several purposes :

> "Focus group interviews maybe used for instrument development, illustration, sensitization or conceptualisation" (p1282)

They are a useful strategy when the researcher wishes to allow questions to be responded to from a variety of dimensions.

Several factors influenced the decision to employ focus groups as the phase 1 data collection strategy. Initially, consideration was given to questioning in hermeneutically guided research. It was important that the researcher's pre-understandings or assumptions were not the driving force in setting the research agenda. In her discussion of Heidegger's approach to the hermeneutic circle Taylor

(1994) comments :

> "Heidegger began his hermeneutical enquiry into Being by examining the formal structures of questioning itself...." he "....shifted from the question to the essential act of questioning. In so doing, Heidegger uncovered certain apriori objective and subjective forms. The final step was in arguing that to raise a question the questioner, must have some idea of what to ask." (p44)

Although the notion of 'pre-understanding' is not exactly akin to the concept of bias, literature on this issue was useful. For example, in order to reduce the possibility of introducing researcher bias into her work, Lankshear (1993) selected focus groups as a method of data collection. She reports that participants were :

> "allowed to explore the topic in their own words, thus defining the important issues."(p1987)

Hedges (1993) identifies a number of positive and negative aspects of group interviewing. One positive feature can be that groups provide a social forum allowing participants to hear and consider other participants' opinions. This may then trigger their thought processes. This was considered to be an important quality for this research which was addressing the issue of constructed meaning, which is often tacit and which participants may not have been asked to articulate before. The meaning of their experience may be 'taken-for-granted' and transparent to them, so triggers to stimulating articulation may be important.

Another plus of group interviewing is that a number of participants' opinions can be accessed at the one time. Although this can have the potential of limiting the depth of

discussion, at this stage in the research, in view of the fact that it was to be complemented by other data collection methods, this was not identified as a problem. Another feature of group, as opposed to individual, interviews was that it was hoped that the discussion would identify examples of practice which would be appropriate for observation in the next phase of the research. In other words, types of practice incident which could be rich in meaning would potentially be identified. This perception will be returned to in the reflective section of the discussion.

Focus groups : implementation

Group composition was an initial issue for consideration and a decision was made to have homogenous groups. Nyamathi and Shuler (1990) favour homogeneity in the interest of group cohesiveness and smooth communication patterns. I considered that this would allow the discussion to be more open and not restricted by any status / student / teacher relationship issues of a mixed CHN /student group. By interviewing the students in a group in the college setting, it also avoided impinging on their clinical placement time with their mentor.

The literature suggests that focus groups should ideally have 7-10 participants. Although aware of this suggestion, the number of attenders varied between 3 and 10. These numbers were determined by CHN availability on the day and the practicalities of meeting their caseload demands.

The student groups met in the college setting. They were therefore on site and minimal effort was required for their attendance. Table 3 provides attendance details.

Table 3 Student Focus Group Attendance

STUDENT FOCUS GROUP INTERVIEWS	
Agreed to attend	Attended
4	4
10	10
9	8
7	7

Identifying days and times that were convenient for a number of community staff required considerable co-ordination. The diversity of responses received from the request to identify convenient days and times for the focus groups are presented in Appendix 3. It was only possible to identify 4-7 CHNs available to attend any individual focus group. This left a very small margin for drop out. CHN attendance is detailed in Table 4. Four focus groups and one individual interview were conducted.

Table 4 CHN Focus Group Attendance

CHN FOCUS GROUP INTERVIEWS	
Agreed to attend	Attended
7	4
6	4
4	1*
5	0**
4	3
5	4

* only 1 CHN presented .Others had withdrawn at very late notice making it impossible to inform all participants and rearrange. The CHN agreed and indeed was keen to participate in an individual interview.
**The sector manager called a CHN meeting at short notice which prevented attendance at the focus group

Non-attendance was generally not a result of lack of commitment to the research, but rather an indication of the problems of conducting this type of research in the community setting with a mobile population with different workload agendas and demands. The main reasons for non-attendance are detailed below:

- Time delay between arrangement and occurrence, despite reminder messages

- CHNs can be difficult people to contact i.e. they work from a variety of bases and are mobile

- Although the groups took place within their community locality, this did require most participants to travel to a central venue

- Patient needs had to be prioritised, therefore urgent calls had to be responded to, absent colleagues workload had to be covered

- A CHNs working day can be very individual and is highly flexible i.e. if the morning workload takes longer than expected, a pre-arranged focus group meeting cannot be attended. The CHN has no option but to finish the work - there is no-one else to take over as there would be in a ward situation

Some researchers advocate providing participants with trigger questions in advance of the interviews or asking then to come prepared to discuss a clinical issue/incident (Benner and Wrubel 1982). However, in view of the earlier discussion on researcher pre-understandings, it was decided to attempt to avoid imposing my structure on the discussions, trigger questions were not sent to participants in advance of the focus groups. I very much wanted to provide an environment for the participants to express their practice meaning. In an attempt to adhere to phenomenological

philosophy, whatever they deemed appropriate for discussion was of interest. However, to allow them to prepare in some way for the group and to allow them to be aware of what they were agreeing to participate in, a brief letter about the focus groups was given to participants in advance. This is reproduced in Appendix 4.

The focus groups were intended to be a discussion about their world and the meaning it had for them, it was definitely not intended to feel like a formal research data collection exercise. Benner (1994b) gives the following advice:

> "Because interpretive phenomenologists study everyday practical knowledge and events, the communicative context is set up in naturalistic ways so that the participants do not feel unduly awkward and constrained by the research interview or foreign, abstract language." (p108)

Although I imposed limited structure on the interviews, the approach was interactive. Similar to the focus groups reported by Green and Holloway (1997) in their phenomenological study, qualities of 'permissiveness and acceptance' were important. The groups were physically set out in a circle fashion and a fairly unobtrusive tape recorder was placed on a low table in the middle of the circle. None of the participants had any objection to the discussions being audio-tape recorded. My role was as facilitator rather than contributor i.e. allowing someone who was trying to comment to be allowed into the discussion, prompting for explication of an issue. Brief notes were also made by the researcher during the interviews - whether non verbal reactions of members of the focus were positive or negative or if a particularly striking or apparently meaningful comment was made. The atmosphere was relatively relaxed, with refreshments available during the interviews.

Each group was given the following introduction:

> *"I'm interested to learn more about your experience of nursing in the community, what it means to be a community nurse, to practice nursing in the community."*

Although the purpose of the groups was to explore the question 'what meaning does the phenomenon of community have for you', an oblique approach to this question was adopted, grounded in modes of discussion that would hopefully be readily accessible and familiar to the participants. Jones (1985) advises that when trying to understand another person's construction of reality you need to ask them is such a way that they can tell you in their own terms. Erikson and MacKinnon (1991) used a similar approach with teachers and student teachers which appeared to work well.

One theme for discussion was the clinical curriculum, the agenda for learning from/through practice. The intention was to attempt to shed light on participants views on the framework of practice. Schon's 'naming and framing' concept referred to earlier was influential here. Continuing with the learning/teaching theme, CHNs were asked to describe the qualities of a good student, the kinds of practice they wanted to see displayed before they would consider the student competent. 'Competent for what' has not been well defined in the profession, but in this instance it refers to identifying a student who would be able to take up a post as a novice community staff nurse. CHNs were also asked to identify aspects of practice that were difficult/easy for a learner to understand. The rationale for these questions was to further explore the community phenomenon by rooting out what CHNs considered to be essential characteristics to function in the community context.

Sometimes the discussion developed to naturally include the topics without any direction from the researcher. However, when necessary, the following questions were used in the CHN focus groups:

- What do students have to learn during their community placement ?
- If you had to sum up community nursing, what would you say ?
- How would you compare practising in the community and hospital settings?
- How would you describe a 'good' student ?
- What are you looking for when you assess the students, are there any really important issue for you ?
- Are there any aspects of community nursing that you specifically want students to experience/learn about during their placement with you ?

For the student group the questions focused on new learning and transfer/adaptation of previous learning:

- If you had to sum up community nursing what would you say ?
- What are the main features of community nursing practice ?
- How would you compare practising in a hospital and practising in a community setting ?
- What have you learned during your placement ?
- Would you consider working in the community when you qualify ?

Discussion was active in all the groups. At the conclusion of each group, I summarised the main themes of the discussion in order to clarify and verify the content with the group.

The number of focus groups had not been pre-determined, although this had originally been planned to be the first phase of a multi-phase study. After four focus groups with both students and CHNs no new information appeared to be emerging. It therefore seemed appropriate to conclude this phase at this point.

Focus group : some reflections

On a very practical level, co-ordination and organisation of the CHN focus groups was difficult to achieve. The format of each CHN's day can differ considerably, making a protected and convenient time quite difficult to achieve. Linking focus groups to another service led meeting where time could perhaps be more protected would be one way to resolve these problems.

Taking a comparative route, in line with the approach described by Erikson and MacKinnon (1991) proved a productive decision. Both groups were able to make broad distinctions about each other and this proved a useful forum around which to revolve some of the discussion. Asking CHNs to make comparisons between themselves and students was an effective route in terms of accessing more detailed rather than surface data.

The participants appeared to enjoy the opportunity to talk about practice. There was general agreement with one CHN commenting :

> "It's been such a change to talk about nursing like this, not just about problems, but what it's all about - we so rarely get the chance to think about these things, we just go about doing it." [chnfg 2]

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chnfg = community health nurse focus group

Although this was an 'aside' remark, given as we were leaving the venue, it has considerable significance for the aims of the study. It reinforces that this level of discussion does not generally take place and strengthens the need to broaden perceptions of knowledge in practice professions. It also allowed me to more clearly appreciate Heidegger's comments about the level of description required for interpretive phenomenology. He advocates that second order reflection, reflection brought about in response to something going wrong is not the desired level. Rather, the taken-for-granted, pre-reflective level of description should be sought. This CHN was echoing the same sentiment - we had been discussing nursing for the sake of it, not in response to or in an attempt to resolve a problem or issue.

Although detailed discussions resulted which shed some light on how students and CHNs make sense of nursing in the community context, the CHNs at times struggled to develop some of the issues they raised. They tended to talk in broad terms and could not readily access practice detail on which to hang the discussions. The level of reflection expected of the respondents is an important issue to raise. They were being asked to return to an amalgamation of experiences, rather than discuss particular experiences. This is an important methodological issue. The content of the participants discussion may have passed through several levels of reflection. The discussion was focused on practice, but at the same time it was detached from actual practice.

The focus groups allowed the participants to communicate about their actions and perceptions and fuelled enthusiasm for the research. Questions and discussion about

the meaning of practising nursing in the community were met with a commitment from the CHNs that there was something distinctive about practising in this context. However, the rationale behind their comments was not very apparent. They felt that they did have something to say but at this stage were experiencing difficulty in articulating it. Some other means of assisting the participants to describe their experiences authentically and fully was required.

This was a typical CHN comment :

> "There are differences between me and the student, we see different things, it's difficult to describe" [chnfg 1]

Further prompting for an example received this response :

> "I know there are examples, I just can't think of one, it's difficult after it happens. But really, you would have to be there." [chnfg 1]

This phase of the research endorsed the view that it is difficult to articulate the meaning practice has for the individuals involved. Difficulty in accessing meaning is not something that is limited to this subject area. Reference to the work of Heidegger and the notion of transparency is very helpful in trying to understand the situation. Briefly, he suggests that a subject may not always be conscious of the totality of their world, elements become transparent. The word 'transparent' warrants further discussion because of the potential for different interpretations. 'Transparent' could be interpreted as meaning 'crystal clear'. However, the Heideggarian interpretation is 'invisible through familiarity'. Review of phase one suggests that this may be one explanatory factor in the accessing difficulties experienced. The CHNs particularly may not always be aware of the structures which provide meaning to their clinical world.

Reference was made earlier to the work of Rubin (1981) whose words of :

> "We bring to the surface the latent meanings that lie outside the immediate awareness of the person who speaks them. (p213)

aptly identified the task for the next phase of the research. The meaning inherent in practice has to be deconstructed in order for meaning constructs to be built. The focus of the research therefore had to move from retrospective/ practice product mode employed in phase one to a more concurrent, process approach.

Although the desirability of moving data collection to be more concurrent to practice was raised by the participants, this development also has theoretical roots. This first phase of the research helped to clarify what it means to 'do' phenomenological research. The research had strayed from the principles of pre-reflective description and primacy of the life-world. Participants were being asked to give general comments, not specifically focused on actual experience, but an amalgamation of experiences. This approach still accessed a level of meaning and gave some indication of the issues involved in the participants construction of the meaning of their experience of practice. This realisation also revealed that my initial idea of identifying aspects of practice which would be 'rich in meaning' for the next phase of the research was virtually impossible, but also theoretically inappropriate. CHNs were being expected to abstract aspects of practice which held significant meaning without giving sufficient recognition to 'transparency' of practice. Returning to the principles of hermeneutic inquiry, it is focused on accessing meaning that is hidden or taken-for-granted.

Reflection on my role also brought forth some realisations. In hermeneutic phenomenology, the researcher participates in making the data and exploring the meaning in the data. This quality was significant in deciding which strand of phenomenology to follow. However, lack of experience at researching in this way was apparent during this first phase. I had obviously not entirely rid myself of positivistic research principles as there was still a tendency to avoid 'contamination' of the data and stand a distance from the process. As a consequence of further reading, particularly in relation to Gadamer's perspective on hermeneutics, the role of co - understanding was more clearly appreciated. Koch (1993) helped me to differentiate 'not influencing the data collection' from 'participating in data collection':

> "The idea of Gadamer's hermeneutic circle includes keeping open the dialogue through the notion of question and answer" (p147)

In conclusion therefore, although interesting data were generated in this phase of the research, there appeared to be a strong message from participants and theorists that it would be appropriate to take further data collection closer to practice and description to a pre-reflective level.

PHASE II

OBSERVATION WITH CONCURRENT INTERVIEWING

The focus groups were accessing reflected, rationalised descriptions. To adhere more closely to the philosophy of phenomenology a move away from generalisations and nearer to pre-reflective description was necessary. Accepting that data collection had to move closer to actual practice, and cognisant of the CHN comment 'you would have to be here', consideration was given to how this could be achieved.

'Being there' meant accompanying CHNs on their visits to patients. Practically, it would be difficult to do this when the CHN was also accompanied by a student. However, consideration was given to this option in view of Fish, Twinn and Purr's (1989) use of non participant observation of home visits during their study focusing on how practitioners facilitated student learning. As the focus of my study was not the process of learning but the individual participants meaning construction, I decided that this was an inappropriate and unnecessary level of disruption to expect from the participants.

I therefore decided that non participant observation would occur during a period when CHNs were not allocated a student. Such a request would still place a considerable demand on the CHNs. As has already been stated, an observer in the community setting is very obvious. It is virtually impossible to 'merge in with the background'. There are two specific reasons for this:

- The focus of care is the patient's home. The CHN has to ask permission of every patient for the researcher to accompany him/her during the visit before

entering the patient's home. A researcher in a hospital ward may be less obtrusive and perhaps more acceptable. A 'researcher' coming into your home is a rather different issue.

- The CHN could be involved in caring for some patients over a period of time. This meant that the patients were exposed to a stream of students accompanying the CHN during his/her visits. This was not of concern for some patients, although others had apparently commented about the intrusiveness of so many different people entering their home. The saving grace of the student placement was that it lasted several weeks so there was an element of continuity and it had the purpose of helping someone learn to become a nurse. Contributing to research has a different ring to it and as an observer the researcher would only anticipate accompanying a CHN for one or two days.

For these reasons it was considered that observation was a very precious commodity and would have to be used very cautiously.

Observation with concurrent interviewing : development

An important issue for consideration was what was to be observed. It was important that a 'normal' day's practice was experienced by the researcher. The research is about real life, taken for granted issues i.e. naturally occurring activities.

The purpose of accompanying the CHNs was not just to observe their practice, but to enable me to *'be there'*, be close to practice so that we could access the experience and discuss its meaning as near as possible to when it occurred. The discussion could then be anchored in practice rather than reflection on practice. It was assumed that

being in practice would facilitate understanding how the CHNs were 'situated' in their world (to borrow Benner's phrase) and how they perceived students to be situated. Bousefield's (1997) comments were particularly influential at this point in clarifying the idea of concurrent interviewing during the periods of observation. She talks about being able to construct the meaning of experience through intensive dialogue with individuals living in the world. This refined the concurrent interviewing idea to one of dialoguing with the CHNs about their experience of practice. The philosophy is seen by the researcher to be linked to Gadamer's 'fusion of horizons' idea - indeed, how could we fuse horizons without dialoguing?

The dialoguing idea was further refined with reference to van Manen's (1990:66) description of phenomenological interviewing :

> "In hermeneutic phenomenological human science the interview serves very specific purposes: (1) it may be used as a means for exploring and gathering experiential narrative material that may serve as a resource for developing a richer and deeper understanding of the human phenomenon and (2) the interview may be used as a vehicle to develop a conversational relationship with a partner (interviewee) about the meaning of an experience."

Although not part of the initial plan for observation and interviewing, at this point during the process I realised that in some ways I was also emulating the CHN /student relationship. Theirs is a relationship where the student observes followed by periods of dialogue. This provided an additional perspective to the observation phase, a realisation that I may be able to bring to life some of the comparative issues raised by CHNs and students in the focus groups. The research therefore also had an additional dimension of in some ways tapping into the lived experience of education.

Boud, Keogh and Walker's (1989) discussion on turning experience into learning was brought to bear at this point. In particular their discussion of reflection being problem based or problem solving, in other words you engage in reflection when you have problems understanding or making sense of something. This appears to have much in common with Husserl's second order reflection. I was therefore forced to question whether this indeed was the most appropriate or effective form of reflection for learning in the practice setting as it would appear to sustain 'transparency'.

To summarise, the rationale for the second phase of the research, observation with concurrent interviewing was to :

- experience the practice situation, the world which the two major participants in this research (students and CHNs) were being asked to describe and give meaning ;

- to be in a position to explore the meaning of practice as near as possible to as it was happening ;

- to be cognisant of the issue of transparency. As Benner, Tanner and Chesla (1996) say :

  "In direct observation of practice there is a temporal immediacy and proximity to the extingenices of that practice that is less available in narrative presentations. The context which may be invisible for the practitioner because of familiarity stands out for the observer." (p358)

- mutual experience (in terms of physically being there as opposed to meaning construction) of a situation /clinical event allowing interactive dialogue.

My role as researcher was therefore similar to that described by Benner, Tanner and Chesla (1996) as being one of thoughtful observation and discussion. The focus of the activity was dialogue carried out before and after each patient visit/encounter.

Field's (1991) advice on 'doing fieldwork in your own culture' was taken into consideration when preparing for and implementing this phase of the research. Specifically she highlights the problem of entering into a setting and perhaps not seeing all that is there because of familiarity with the setting :

> "Someone once said, 'If you want to study water, don't ask a goldfish.' " (p94)

I had experience of practising nursing in the community context, but from a health visiting perspective. The research setting was therefore the researcher's 'culture' to some extent, but through experience with a different community speciality. The time lag since being a practitioner rather than an educator also contributed to the feeling that a degree of distance existed between the researcher and the culture being researched. Nevertheless, a definite effort was made to be vigilant to all the qualities of the setting. Van Manen (1990) refers to 'hermeneutic alertness' being an important characteristic of the phenomenological observer. This encourages the observer to step back and reflect on the observation experience.

Observation with concurrent interviewing - implementation

During the initial consent process some CHNs had already agreed for the researcher to accompany them on visits. They were contacted again to verify that they were still willing to participate. During this consent seeking activity, I recounted a summary

of the outcome of the focus groups about 'having to be there'. I felt that if I could show that the idea had been endorsed by the CHNs it would be more likely to receive a positive response. All the CHNs who had initially agreed to participate restated their willingness.

The process of selecting CHNs was done in a very practical manner. A list of days when the researcher was available to accompany CHNs on their visits was circulated. Only a percentage of the potential sample was available at any one time. Exclusion factors included :

- having a student nurse allocated to them during that time period;
- being on days off;
- being on annual leave/sick leave/study leave;
- covering a colleagues caseload in their absence. They were therefore unfamiliar with the patients and felt it inappropriate to ask the patients to permit an observer to accompany them on their visits.

The responses were collated and arrangements made to visit with whichever CHN was available on the day. This exercise was repeated five times to allow five episodes of observation to take place. If a CHN who had already been accompanied was available as well as someone who had not been accompanied, the latter was selected to increase the diversity of meaning potential available.

The process of the observation session was similar on all occasions and took the following format. I met the CHN at a designated base at approximately 8.30 am. I reiterated that the purpose of the observation was to allow me to experience and

discuss practice with them in order to work on the research question of exploring the meaning of practising nursing in a community context. The following opening remark was made at the beginning of each observation period:

> *'I want to experience a normal day's activity. I appreciate that you have to ask permission of each patient for me to accompany you. If there are any visits you do not wish me to observe or if you wish me to leave at any point I will be vigilant to these possibilities.'*

All the CHNs agreed to allow me to tape-record our discussions. A small tape recorder was therefore placed in an open shoulder-bag and switched on at all times except during the home visit. This seemed to work well, was unobtrusive and did not appear to curtail the process of the discussion. Tape recording allowed me to engage in active listening and dialogue rather than be concerned with recording data during the observations.

Permission was requested by the CHN from each patient for me to observe the visit. This was always granted.

Some notes were also made about any feelings I experienced or details about the patient situation /care that the CHN did not discuss but which appeared significant to me. For example, one visit was to a middle aged professional man who was suffering with a neurological disease. His existence appeared very minimal and spartan, apparently spending his life in a small, rather dark room smelling faintly of urine. He was an articulate man, although his speech was very slurred and difficult to understand and he appeared to be very under-stimulated. His 'lot' had a significant effect on me and I felt rather distressed about what appeared to be a very poor quality

existence. As the CHN had been visiting this person for some time, she was obviously accustomed to the situation and naturally did not have the same reaction to the visit as myself having being exposed to it for the first time. Although the significance of these notes was not pre-determined, I made them just to capture as much of the experience as possible. They were used later as another level of data to guide analysis and interpretation.

Another issue was also triggered for me as a consequence of this experience. Posing the question 'Would students experience the same uncomfortable feelings as I did ?' reminded me of Schutz's 'streams of consciousness' concept and I wondered how often this was acknowledged in the learning situation. Although this was second order reflection i.e. it had been triggered because of my unease in a situation it is relevant to the issue of teacher/learner vigilance to the others experience of a situation.

Field (1991) refers to research carried out by Estabrook, an intensive care nurse researching the intensive care setting. She reports extreme difficulty coping with the emotional aspects of the care. She rationalised the difficulty experienced in the researcher, but not the practitioner role, because defences usually in place when practising in the intensive care setting were not sustained in the researcher role.

It is possible to offer another perspective as a consequence of my experience in this study. It may be that CHNs have developed coping mechanisms or barriers in order to allow them to meet emotionally demanding situations, in much the same way as

the intensive care nurse has done. For students the primary focus of learning may also form some sort of protective barrier. Their train of thought may be directed to 'what is demanded of me in this situation'. The researcher however, is actively exposing him/herself to the experience and may therefore be more vulnerable to heightened, unfiltered responses to situations. These issue may be important when considering if the 'researcher as an observer' role equates in any way to the 'learner as observer' role.

I debated about what, if any, structure to impose on the concurrent interviews. The CHNs often went into mode of discussing clinical detail with a fellow nurse. I did not feel that this was developing our dialogue about the community as a context of practice, rather it was steering the discussion towards technical, procedural issues. I 'tolerated' a certain amount of this for several reasons :

- I did not feel that I could be too restrictive with regard to the parameters of conversation i.e. I did not want to make the situation false or over emphasise the data collection restrictions of my presence. In order to maintain/ nurture co-operation in this and future aspects of the research I felt that there had to be a balanced agenda;

- I wanted to allow a degree of flexibility as some other pertinent aspects of conversation may have developed;

- discussion of clinical issues often helped to move on to the specific focus I wanted to take.

However, this negotiation of content of the concurrent interviews was a source of tension and I struggled to determine where the parameters of phenomenological

research lay. Reference to placing structure on this interview situation appears to contradict earlier comments about avoiding researcher imposed structure. My problem revolved around whether it was appropriate to try to enforce some level of restriction on the discussion when what was being sought was their lived experiences? Where, for example, did discussion on the latest dressing fit into the schema ? On balance it was considered that the restrictions placed on the scope of the interview discussion were in fact congruent with phenomenological philosophy and necessary to encourage participants to focus on this level of discussion i.e. experience accounting rather than activity description. Van Manen (1990) describes the phenomenological observer as a gatherer of anecdotes. In so doing :

> "...one needs to be quite rigorous and construct accounts that are trimmed of all extraneous, possibly interesting but irrelevant aspects of the stories. An anecdote is a certain kind of narrative with a point, and it is this point that needs honing." (p69)

The process he describes has similarities to the process encountered in this research.

Consideration of the problems described raised other issues. It caused a re - evaluation of the researcher/CHN relationship. It raised my awareness that although in these circumstances I identified myself primarily as a researcher rather than as a lecturer in community nursing, this distinction may have been blurred for the CHNs. It therefore had to be acknowledged that there may have also been an element of using the interview to also demonstrate the quality of their knowledge base to someone from the local educational institution. Field (1991) raised the potential problem of role differentiation when researching in your own culture. The research participants, both CHNs and students, probably identified me as a nurse lecturer

doing research. However, as the research had an education focus, this was not seen as problematic and indeed may have provided openings denied to an outsider researcher. The value of using professional credibility to gain access to research situations, obviously has to be tempered against the potential ramifications for participants perceptions of the researcher role.

Another issue called into question was what was the focus of the concurrent discussions which routinely took place between CHN and student. Fish, Twinn and Purrs' (1991) comments about mentors relating practice back to propositional theory rather than sharing practice theory were recollected. This issue is in addition to the pre-reflective and a second level reflections already discussed.

The CHNs gave me brief information about the patient before we entered each house and discussed the outcome of the visit during the drive to the next visit. Comparison between CHN and students was still used as a route to accessing meaning rather than as a comparative exercise in its own right. For example I posed questions such as:

"What would you want a student to learn from that visit ?"

" What do you think a student would 'get out' of that visit. ?"

"Was that visit a 'good' example of *community* nursing ?"

The interviewing could be described as having two purposes. First, it was used to gather one dimension of lived experience accounts of nursing in the community context. Secondly, there was also a hermeneutic element whereby the researcher and participant engaged in reflection and dialogue of the experience.

Several patients we visited also received care from another member of the community nursing team i.e. the nursing assistant and/or an informal carer, generally a family carer. This provided a natural vehicle to explore the meaning of community nursing as opposed to caring in the community setting.

Finding an unobtrusive observer role was quite difficult. In the usually confined space of the client's home I felt that my presence was always obvious, although I attempted to position myself so as not to obstruct the CHN or patients/carers activities. At times the CHNs left me alone with either patient or carer while they, for example, washed their hands prior to carrying out a dressing. This was at times an uncomfortable experience, I was a stranger to these people, I was cautious about what to talk about with them, not knowing their situation or needs in detail. I had been permitted to accompany the CHN as a researcher, the limits of the role were vague. The intensity of this experience raised questions of what the experience was like for students. The newness of the situation may actually provide a buffer for them and prevent them experiencing some of these reactions.

Reference to the earlier discussion (Eisner 1991) about perception development might be useful in clarifying the experience. The development of enhanced levels of perception as a consequence of professional maturity may be influencing this situation. Trying to answer this question is not the focus of this research, but the point has to be raised as it supports the need to clarify learning in the practice setting from an experiential level.

One of the concerns when planning this phase had been the potential impact of a third person on the home visit. Other researchers, for example Luker (1978) and Field (1980) report that in their research patients appeared to accommodate to the researcher once the nurse/patient interaction had commenced. Field suggests that if the researcher is introduced as a 'nurse-researcher' the client/patient often merges the roles. Using the 'nurse-researcher' title presumably means that the client/patient at least does not have to accommodate to a new role in their environment. The level of accommodation by the patient can mean that a triadic relationship essentially reverts to the usual dyadic. I would question whether this actually happens when the environment of care is the patient's home.

On one level, the presence of a third, non participating party was physically very evident in my study. The impact on the process of the nurse/patient interaction of a third party is more difficult to evaluate. Certainly, with respect to students, CHNs have repeatedly reported to me that patients allow the triadic relationship to affect their interaction and hold back on some issues until the next time they experience a dyadic relationship with the CHN. CHNs did not suggest that they surmised this had happened during any of the visits I observed. I think it may be worth exploring who the 'extra' person is and how that person presents rather than just thinking about a dyadic relationship changing into a triad. I would offer the suggestion that as an experienced community nurse I may have been able to adapt to the role of nurse in someone's home more easily than a third year student nurse. It may be therefore that 'insider' knowledge or experience is an important variable when considering this type of research method.

Observation with concurrent interviewing : reflection

This was a productive phase of the research for three reasons:

- it provided an opportunity for considerable data collection about the meaning of practice for the participants which was actually anchored in the lived-experience of community nursing;

- it allowed the relationship between the researcher and CHNs to develop further;

- it allowed me to encounter the snap-shot view of the practice (although more condensed) which students experience.

Time was very restricted and on occasions our discussion had to be curtailed. For example the CHN would pull up outside the next patients home and literally have to say 'Sorry we can't talk about that any more, we're at the next visit'. This may have implications for teaching practice to students i.e. unpacking the detail of practice. As context of practice is pivotal to this research, it is prudent to question whether a similar situation would happen in a hospital ward environment. In the community, patient encounters generally appear to be closed, discrete experiences. This may have an impact on teaching/learning encounters although returning to base provided an opportunity to resume dialoguing about an experience. This was the pattern experienced during the observation period.

Almost every visit raised issues about the meaning of practice for the CHNs. They always had something to say about what they felt a student could learn about

practising in the community from different visits. This reinforced the belief that there was a phenomenon worth exploring further.

Deciding how many observation episodes was sufficient required careful consideration. Lincoln and Guba (1985) suggest that one means of enhancing credibility of qualitative research is to be involved in prolonged engagement, spending sufficient time on the data collection process. One reason for this is to develop rapport with the participants. As observation was the second phase of the research study, rapport has already begun to develop with the participants. For this reason, I judged that limited observation time was put to maximum effect.

After five observation sessions, it was decided that further observation would be unfruitful for two main reasons :

- the aims of this phase of the research had been achieved in that I had heightened my awareness of the world of community nursing and in the concurrent interviewing it had been possible to access lived experience description and begin to mine the meaning in conjunction with the respondents. I also spent considerable time after the observation sessions reviewing the transcripts and notes inorder to continue the 'mining' process. Further episodes of observation would merely place an excessive demand on the CHNs and patients;
- the student perspective on actual practice episodes was required which could only be accessed through a different research strategy.

The next phase of data collection therefore was to move from hermeneutic interviewing to a strategy which would allow CHN and student pre-reflective descriptions of their practice experience. The task of developing a means for the participants to tell their practice story which did not require the presence of the researcher led me to consider methods of narrative recording.

Consideration was initially given to asking CHNs and students to complete a diary of a mutually experienced visit. This strategy was piloted but it was not practicable. It was extremely time consuming and appeared to result in an abridged version of the total experience being recorded.

Accordingly, a more convenient option seemed to be for CHNs and students to use tape equipment to verbally record their experience. The development and implementation of this strategy is discussed in the next section.

PHASE III

Practice Narratives

The aims for this third phase of the research were to access student and CHN accounts of the same experience of nursing in the community at a more spontaneous and pre-reflective level. Their accounts were to be anchored in lived-experience, therefore they had to be accessed as near as possible to when the experience occurred. This would have the effect of limiting the temporal impact of aspects of the experience being forgotten. It would also reduce the reflective/rationalisation period by attempting to approximate to the phenomenological principle of pre-reflective data.

Van Manen's (1990) discussion on lived experience descriptions was useful in developing this aspect of the research. He refers to 'protocol writing' - asking someone to write down their experiences as one way of accessing lived-experience descriptions. 'Protocol' as derived from Greek means 'first draft'. However, he also suggests that most participants would generally achieve greater levels of eloquence, lesser degrees of reflection and higher levels of user compliance if lived experience was spoken rather than written. This supported the rejection of the diary strategy already reported in the previous section.

Narrative, which Stuhlmuller and Thorsen (1997:141) describe as "a basic medium for conveying understanding and creating meaning of experience" appeared to be an appropriate strategy to access these data.

Constructivism also contributed significantly to the development of this research strategy. Stories or narratives are, after all, individual constructions of experiences or events. According to Stein and Apprey (1990) :

> "Treatment plans, theories, religions, political movements, are all efforts to construct stories (narrative or discourse, in social science terminology) that create and impose coherence and meaning on the inner and outer worlds alike." (p1)

Narratives were therefore seen as a vehicle to further expose and construct practice meaning.

Practice narratives : development

The development of this approach was informed particularly by Benner's work on nursing narratives. The rationale of the method is clearly detailed by Benner (1994b):

> "The role of story telling is central to interpretive phenomenology because when people structure their own narrative accounts, they can tap into their more immediate experiences and the problem of generating false generalities or ideologies is diminished." (p108)

Mattingly (1991b) used story-telling in her research focusing on the practice of occupational therapists. She suggests that stories are a way of giving 'meaningful form' to our lived experience. She identified two styles of discussion used by practitioners :

> "One was a biomedical discourse, a language I came to call 'chart talk' because it conformed to discourse in the medical charts. The other was a narrative discourse, a language of personal experience." (p244)

This remark suggests that practitioners would perhaps already be engaging in voicing practice narratives as a natural part of their discussions with colleagues and may

therefore be something they could easily adapt for this study. More than just being an acceptable method, narrative also appeared to adhere to the phenomenological philosophy. Again to quote Mattingly:

> "...thinking through story telling achieves a different type of sense making than thinking through a propositional argument or paradigmatic thinking. .....Narratives make sense of reality by linking the outward world of actions and events to the inner world of human intention and motivation". (p999)

This seems to have relevance to the Heideggarian perspective of not separating subject and object but focusing on *dasein.*

Story-telling may actually be very appropriate for community practice:

- community practice is episodic, the start and the finish of each visit can be clearly delineated. This gives a clear episode to record. In comparison in a hospital situation the contact with a patient potentially lasts a whole shift;

- as a consequence of working alone, CHNs habitually return to base and take the opportunity to relate their days 'story' to colleagues.

Linking back to Benner's concept of situated possibilities, Mattingly's assertion that there is :

> "...pluralism inherent in story telling, the fact that different actors will tell different stories about the 'same' situation." (p249)

reinforced this strategy as a means of accessing CHN and student experiences of the same practice encounter.

Ricoeur (1981) says that a story 'describes a sequence of actions and experiences'. However, this is only half of the narrative content. As well as the episodic element, there is also a configurational element. In other words, narratives or stories recount events, but also have a 'plot'. Producing the narratives was therefore only part of the methodology. According to Ricoeur :

> "...the activity of narrating does not consist simply of adding episodes to one another; it also constructs meaningful totalities out of scattered events." (p278)

Part of the intention of the research strategy was therefore to use the practice narratives to help construct meaning. As this research is rooted in dialogue and aims to achieve a 'fusion of horizons' I did not just want to access a story, but also some means of understanding the meanings of the experience told in the story. I considered it important that I worked with the participants to 'make sense' of the narrative transcripts. The process of doing so, narrative discussions, is discussed in the next section on phase iv of the research.

Practice narratives : implementation

CHN and student pairs were provided with discreet recording equipment and asked to record a narrative on a mutually experienced practice episode. They were provided with some written guidelines of what was expected of them and these are presented in Appendix 5.

I was mindful of Crotty's (1996) criticism of how other nurse researchers have attempted to access accounts of lived experience. He identifies that strategies to

encourage or enable research participants to 'get in touch' with their pre-reflective experience are lacking. He stresses that :

> "...the focus should lie with what 'manifests' itself in experience rather than with what the subject has made of it. (p56)

He identifies one nurse researcher, Rose (1990), as providing appropriate guidance for research participants. She reportedly asked her respondents to 'set aside personal theorisations'. I considered this approach with some reservation as this type of language was contrary to the conversational mode of communication I had adopted and which is advocated by Benner, Tanner and Chesla (1996). While wholly acknowledging the principles identified in Crotty's discussion, advice offered by Benner (1994b) was more in keeping with the approach I had adopted. She acknowledges that both researcher and respondent may initially require coaching in narrative generation. She advocates that:

> "... participants must be instructed that narrative accounts of events, situations, feelings, and actions are wanted." (p108)

The intent was to share interpretation of the narratives with the participants in the next phase of the research, and permission to share anonymous transcripts with other participants was sought and granted at the start of the process.

The community environment set several restrictions on where and when the narrative could be recorded i.e. the impracticality of recording the narrative in the patient's home, the CHN and student sharing a car, confidentiality problems of recording outside the car. In practice, therefore, it was only feasible for them to make the narrative recording when they returned to a clinic or GP base. Selection of which visit

to record was therefore highly practical i.e. it was the last or second last visit before returning to base since this was their most recent experience.

Most participants had some concerns about recording their thoughts, 'How will I know I'm saying the right things?' Considerable effort was therefore made to assure them that there was no right or wrong way, but that their account of their lived experience was what I wanted to know about. They were provided with the recording equipment during the early part of the six week placement but all chose to use it during the last two weeks. They were given a supply of tapes and were told that they were free to listen to the recordings and erase any which they did not want to share with the researcher. This level of control appeared to considerably reduce their anxiety.

Seven CHN and student pairs participated in this phase of the research , producing 18 narratives.

Practice narratives : reflection

Some CHN/student pairs were more comfortable with using this style of recording than others. However, it proved a useful way of accessing accounts of their lived experience, and uncovering their naturally occurring concerns and meanings, or to use Schon's phrase, the 'naming and framing' of their clinical experience. It would therefore be reasonable to conclude that the narratives captured two levels of data, the pre-reflective as well as some degree of the CHN or student rationalisation of it.

Almost without exception, the CHN narratives were longer and more detailed than the student narratives. However, both narratives were generally anchored around the same chronology of events occurring during the visit. The significance and interpretation of the events differed between student and CHN. In other words, CHNs and students drew on the same incidents but placed different emphasis or detail.

It was stated earlier that this research was aiming at dialogue and 'horizon fusion'. The process of achieving this with respect to the narratives was developed in the next phase of the research.

PHASE IV

Narrative Transcript Discussions

As discussed earlier, the narratives were developed as a two part research strategy. The individual practice narratives captured a description of the participants' lived experience. The narrative transcript discussions were intended to access another type of narrative, namely 'the story behind the story'. This 'follow-on' phase is in keeping with the search of the hidden meaning which is central to the guiding philosophy of hermeneutic phenomenology. Discussions were therefore planned to both explore the individual narratives and also potentially the inherent 'hidden' story and should therefore be seen as the concluding part of the narrative process.

Narrative transcript discussion: development

Narrative discussion groups had three purposes:

- to verify that the practice captured was typical. The desire to ensure 'typicality' is not really a requirement of this research process, more an issue for me feeling the need to know that this research was saying something relevant to the wider world of community nurses;
- to continue on the meaning spiral and to capture another source of data and insight;
- to provide me with an opportunity to continue to share the development of meaning interpretations with the participants.

As the transcripts were produced during the student's last placement on the programme, they were not able to discuss the transcripts after production. The discussion groups therefore only relate to CHNs.

A major issue for consideration was whether it would be appropriate to simply share each transcript only with the person/s who had produced it, or to open the sharing to a larger group. The issues of 'transparency' and 'taken-for-grantedness' assisted in directing me to open the discussions to a wider audience than the original story teller. Other participants may be able to view some issues which were transparent to the originator.

The literature on the use of vignettes as a research methodology was explored to assist the development of this phase of the research. They are reported to be a convenient method of collecting data from a large sample. Gould (1996) reports using vignettes which she defines as 'simulations of real events'. They were utilised to elicit participants' knowledge or opinions of the events portrayed. In this study, real events did not have to be simulated, the practice narratives were sited in practice, produced by the participants and not derived by the researcher. This is an important issue in phenomenological research.

Another useful source in the development of this research strategy was Mattingly (1991a,b) who reports a similar idea in her research, although she used video rather than audio recordings as the data source. She taped therapists during their clinical work and then showed the tape to a group of occupational therapists to facilitate

reflexive story telling. The therapists were then each asked to 'tell the story' of what they saw:

> "Invariably the therapist told a different story" (p252)

This finding that multiple interpretations were offered is relevant to this research with the CHN/student comparison element. It is also seen to relate to Schon's 'naming and framing' concept.

Haddock's (1997) discussion on using group reflection as an approach to educating nurses was also useful. She describes action learning groups as a way of sharing the meanings of clinical experiences. The purpose of this approach was to facilitate learning from and through reflection. The approach was adapted to develop a research strategy which would allow meaning to be expressed through reflecting on practice narratives.

Fish, Twinn and Purr's (1991) description of using four strands of reflection in their guide to promoting reflection on practice was also influential in the development of the practice narrative discussions. They describe one strand as 'factual', detailing the experience or event which related to the last phase of this research. Two other strands reported, retrospective and sub-stratum, exploring assumptions and beliefs were influential in the development of the practice narrative discussions.

Narrative discussions : implementation

Four group discussions were organised and a selection of transcripts were presented to the participants. They were given some written guidance as to what was expected

from them and this is presented in Appendix 6. This was in acknowledgement of the complexity of the task we (the participants and myself) faced. Benner (1994b) highlights that :

> "Interpreting a text analogue from everyday practices and concerns is more difficult than reading a constructed written piece of literature that has been composed by the author with the intent of communicating a particular world or perspective. The author of the written text has already struggled with the first level of articulation, whereas research participants will tell stories and events and perform in situations in ways about which they may not have thought." (p103)

Each participant was provided with either three or four paired transcripts. They were given time to read and consider them, make notes on them if necessary (wide margins were provided), before participating in the group discussion.

Although they were anonymous, the CHN and student status of each transcript was always correctly identified by the group participants. The groups were very active and readily engaged in discussion as a consequence of reading the practice narratives. The narratives triggered CHNs to tell more stories of their own experience as well as to discuss what they considered to be the implicit story of the narrative transcripts. They therefore engaged in different levels of discussion, confirming the narratives as telling the story of community nursing and moving through a hierarchy of recounting similar tales and then eliciting what these commonalties said about nursing in the community context.

These discussions were audio-taped and lasted between 45 minutes and 2 hours. The shorter time period was due to time restrictions on participants rather than lack of

discussion potential. The narrative group discussions could be described as a forum for thinking and dialoguing. This phase of the research was drawing particularly on constructivism whereby the CHNs and the researcher's own constructions of the meaning of the narratives was shared. I also continued the reviewing process by returning to the discussion transcripts after the event.

Narrative transcript discussions: reflection

In retrospect, only having CHNs at the discussion group was beneficial. This permitted an openness about the discussion which I do not believe would have been possible if students had been present. The absence of students ensured that the discussion was not a student/CHN teaching/learning session but rather focused on the meaning of the experience for the individual concerned. CHNs were therefore in their role as CHNs, and not student mentors, although they did refer to this role in the discussions.

One CHN did bring her current (first year) student to the narrative discussion. The student made limited contribution and did not appear to be able to engage in 'story telling' about the stories as easily and productively as the CHNs. This may have been a characteristic of this particular student, but may have been a consequence of her junior status, lack of experience and perhaps inhibition to dialogue openly with senior nurses. I would suggest that it would be possible to facilitate student narrative discussion groups, but that this would be a more complex process. For example, it may mean exposing students to very different practice stories to their own. This could

have a subsequent effect on their practice confidence or introduce them to unnecessary conflict about their practice understanding.

Whoever forms the group membership I would suggest that group configuration is an important strategy consideration. Haddock (1997:383) refers to Stock Whittacker (1992) who advises that :

> "...a group works best if its members feel safe enough to take risks... if the sense of safety is low, discussions will be empty and incomplete."

Homogenous groups, together with the longitudinal nature of the research added to the success of the group discussions.

Reflecting on the practice stories of other participants appeared to provide a useful vehicle for participants to explore their own practice stories and the meaning practice had for them. We had entered into different levels of reflection on personal practice stories and practice stories of other participants which added to the richness of the emerging picture.

Summary : Research Design and Methods

Several strategies were employed to access descriptions of the lived experience of nursing in the community context. A summary is provided in Appendix 7.

The four phases of the research accommodated the method requirements of :

- achieving as much realism as possible;
- accessing pre-reflective and reflected accounts;
- avoidance of the reductionist trap with actions described, but denuded of meaning;
- accessing not just words, but the meaning of the words for the participants;
- time efficiency particularly for respondents;
- limitation of intrusion into patients homes;
- unobtrusive data collection i.e. the context was generally very private and physically small environment;
- an atmosphere where participants could feel valued contributors to meaning exploration, rather than data providers.

A number of complementary levels of meaning were accessed and provided a large quantity of rich data. Initially reflected, rationalised material was accessed in the focus groups which formed the first phase of the research. Although deviating in some ways from the principles of phenomenology, this phase provided a good basis for exploring the question and to begin to build relationships with the research participants. It may also have been useful in 'bringing them along' with the research. It was in association with them that the need to 'get nearer to practice' became apparent. Subsequent research strategies were planned in discussion with them. As a

consequence, I believe that their commitment to the research and their understanding of its intention were enhanced.

Observation with concurrent interviewing and narratives provided access to both the participants accounts of their lived experience and to their sense making of these experiences. These accounts were being told for the first time and were nearer to a pre-reflective level of data. They were not concurrent but were anchored in lived-experience rather than generalisations. The practice narrative discussions provided an opportunity to access another level of narrative, 'the story behind the story'. The discussion groups also allowed the researcher and participants to share in the sense-making process in line with the 'fusion of horizon' concept .

Benner, Tanner and Chesla (1996) report that the design of their research was :

> "...influenced by a concern to access practice of nurses in ways that allowed the practice to become visible in all its aspects." (pxvi)

A similar claim could be made for this research whose intent was to allow the meaning of practice in the community setting to become more visible. Focusing data collection on and in practice achieved heightened visibility of meaning for participants and researcher.

The funnelling format of the research, from generalisations to actual practice, was a feature of the initial research design. Although it was only during the focus groups that the accuracy of this design in phenomenological terms was fully appreciated.

The attempt to access meaning in the phenomenological sense brings Meerabeau's

(1992) comments on tacit knowledge to mind:

> "Tacit nursing knowledge: an untapped resource or a methodological headache" (p108)

As anticipated, the research encountered the problems discussed in the theoretical framework discussion. For example Benner's comments on Heidegger's notion of familiarity:

> "...we are so culturally and socially embedded in familiarity with our practice and skills that we lose sight of our being from existing within this familiarity." (p65)

A spiral of collaborative design development and transformations occurred in order to 'excavate' the meaning of experience for students and CHNs. However, by drawing on the interpretive paradigm it was possible to access meaning and achieve understanding.

The community context of data collection raised a number of issues. However, practice narrative recordings appear to offer substantial possibilities to 'be there' *by proxy*, thereby accommodating some of the contextual problems.

CHAPTER 5

ANALYSIS & INTERPRETATION

Introduction

This chapter presents a discussion of how the analysis process was developed, followed by a chronology of its implementation. The analysis process of the research is reported in detail to provide a clear audit trail.

The analysis process is guided by the interpretive paradigm, specifically hermeneutics, the aim of which, according to Allen & Jenson (1990) is developing understanding through interpretation of the phenomenon. Rose, Beeby and Parker (1995) use the phrase 'transforming' to describe the analytic process in phenomenology. Meanings are explored and articulated as they emerge and unfold.

Qualitative analysis

According to Polit and Hungler (1997) qualitative researchers are faced with a number of challenges. One is created by a deficit in analytical rules. Miles and Huberman (1984) describe qualitative designs as often being 'custom built' and therefore without an exact analytical pattern. Baille (1996) suggests that to a certain degree, qualitative research is dependent on:

> "... researcher's sensitivity, perceptively, informed value judgements, insight and knowledge." (p 1302)

Despite the lack of an 'analytical blue print', the process is guided by a number of principles. Firstly, it is not a linear process but an iterative activity, facilitated by the researcher's dialogue with the data. The dialogue is guided by the question,

'what does this say about nursing in the community context' as experienced by CHNs and students. According to Mcleod (1990) :

> "To understand the whole, the parts are understood, part by part, so that progressively more complete awareness of the whole is grasped." (p76)

A second challenge for qualitative researchers identified by Polit and Hungler (1997) is the likelihood of extensive data requiring analysis. This general claim was true for this research because it comprised of four phases, each generating data of differing type and format. Data organisation and management has therefore of necessity been very systematic. This is documented in this thesis with a chronological exploration of the data. This has demanded detailed recording of what has, in fact, been an integrated and iterative activity.

Polit and Hunglers' third challenge is that of achieving an appropriate balance between evidence summary and avoiding inappropriate data compression. The predicament is very well expressed by Sandelands (1991) use of Wordsworth's quote "we murder to dissect". In order to address this potential problem and be cognisant of validity issues, examples from the analysis process are discussed in the text and supplemented with additional examples as appendix presentations. Rather than present aspects of the analysis process in relation to all the concepts identified during the research, one concept is tracked in detail during each phase of the analysis process.

Analysis methods: an overview

Within the phenomenological tradition a number of potential analytical methods were explored. In view of the diverse interpretations of phenomenology discussed earlier (Chapter 3), specifying the particular phenomenological strand is essential to ensure that the analysis process is compatible with the philosophical underpinnings of the research process.

Analytic frameworks

Some researchers, for example Baille (1996) and Green and Holloway (1997) report to have followed specific analytical frameworks. Other researchers, for example Hallett (1995b) report having been guided by a principle rather than a single framework. Examples of both these approaches to analysis are described.

A criticism directed at some researchers is lack of detail or rationale to identify the philosophical underpinnings of the analysis process utilised in their research (Koch 1995). For example, Baille (1996) reports to have employed Colalzzi's method because :

> "...Colaizzi's method has been used for analysing phenomenological data in a number of nursing studies in allied topics..."(p1302)

Baille appears to fall foul of a problem identified by Koch (1995), that of using an analysis method reported to be based on Heideggarian phenomenology in a study reported to be adhering to the Husserlian school.

Colaizzi's method has a number of stages which briefly comprise :

- transcripts are read to develop an overall impression of the data
- significant statements are extracted
- meanings are then formulated by the researcher
- meanings are clustered into themes and sub-themes
- copy returned to informants to verify the representativeness of their experiences

This set method of analysis appeared too restrictive for this study. The study was designed to uncover meaning by collecting a variety of data from different dimensions and more intense levels of understanding were developed as the research progressed. Meanings were therefore returned to and reflected upon several times and interpretation was therefore not achieved by one method or in a single process. Koch (1993) highlights that although Colaizzi's method has a Heideggarian base it does not allow for the researcher to participate in generating or analysing the data. This was seen as a major deficit for this study as researcher and participants dialogued together to explore the meaning of practice.

The overall process of interpretation used in this research had much in common with the phenomenological process described by Lynch-Sauer (1985); a five stage transformation process:

1. "A person's experience is transformed into actions and language that becomes available to him/her by virtue of the special interactions/he has with another person(s)." (p97)

In relation to this research study, multiple transformations occurred by virtue of the different approaches taken in each phase of the research. The range of strategies made a range of experience description available to the participants.

2. "The researcher transforms what s/he sees or hears into an understanding of the original experience."

At each phase in the research the process of re-entering the hermeneutic circle took place developing the understanding. This process was made open to the participants who were invited to participate with the intention that the transformation was not made by the researcher alone.

3. "The researcher transforms this understanding into clarifying conceptual categories which he or she believes are the essence of the original experience. Without doing that, one is simply recording, and recording is not enough to produce understanding."

This process was ongoing and involved gradual merging as linkages were identified in the data, culminating in identifying five core constructs used by these participants to construct their meaning of nursing in the community setting.

4. "The researcher transforms those conceptual categories that exist in his/her mind into some sort of document which captures what s/he has thought about the experience that the other person has talked about or expressed in some way."

During the course of this research study this occurred after each phase to some extent in that some form of updating or reporting was given to the participants. However, the thesis forms the culmination of the transformation process.

5. "The audience of the researcher transforms this written document into an understanding which can function to clarify all the preceeding steps and which can also clarify new experiences that the audience has."

The detail and style of presentation is intended to enhance and facilitate this reader generated transformation.

Levels of analysis

Allen and Jenson (1990) distinguish two broad analytic processes:

- 'textual description' which achieves an explanation, and
- 'textual disclosure' which achieves understanding

Each phase of this research could be said to undergo both of these processes. Initially description of the data from each phase was achieved, followed by further interpretive activity to achieve disclosure. Interpretive activity was an ongoing endeavour and is also addressed in the chapters on 'Meanings and Interpretations' and 'Integration and Discussion'

Benner, Tanner and Chesla (1996) report that in their work '*Expertise in Nursing Practice*' an analysis of exemplars provided the main analytic method :

> "It is through the thoughtful taking up of example after example of practice that the story gets filled in, that understanding is deepened, that qualitative distinctions about practice are grasped..." (p363)

Each phase of this research study could be seen to provide numerous exemplars of practice. The notion of 'thoughtful taking up' describes the process of analysis undertaken in that the data was read, reflected upon, re-read and shared with the participants.

Miles and Huberman (1984) description of the components of the analysis process as consisting of ; initial summarising of the data, identification of themes and patterns, relationship discovery, explanation development and integration was applied to each phase of the research. It was therefore an iterative transformation process.

Theme development

Van Manen's discussion on the process of theme development was important in developing the analytic process for this research. In his book *'Researching Lived Experience'*, Van Manen (1990) discusses analysis under the heading of 'reflection'. He suggests that :

> "The insight into the essence of a phenomenon involves a process of reflectively appropriating, of clarifying, and of making explicit the structure of the lived experience." (p77)

In order to seek meaning, real life has to be 'fixed' in some way around a particular notion. The notion guiding the interpretation of this research study is the community as a context for nursing practice. As situations or reports are examined thematic formulations are made. This process is central to phenomenological analysis and it is therefore important to spend some time considering the notion of a 'theme', 'theme identification' and 'theme types'.

Van Manen (1990:87) identifies four aspects of a theme:

1. "Theme is the experience of focus, of meaning, of point."
2. "Theme formulation is at best a simplification."

3. "Themes are not objects one encounters at certain points or moments in a text."

4. "Theme is a form of capturing the phenomena one tries to understand."

The fourth dimension, that of 'capturing' holds rich meaning for this research. The participants described experiencing difficulty in being able to articulate the essence of community practice. The research process therefore developed in order to 'capture' the issues they struggled to express. It must be acknowledged that any theme or collection of themes probably falls short of capturing the phenomenon completely as a process of distillation inevitably occurs.

Van Manen (1990) details three approaches to uncovering themes. One approach involves addressing the text as a whole. This approach allows for the greatest level of researcher judgement to influence the analysis and limited amount of audit trail detail. A second approach selectively highlights aspects of the text which appear to be particularly revealing about the phenomenon. A sentence or sentence cluster approach is the third option. This current study made most use of the selective and sentence cluster strategies. They were isolated by exploring the data focused on questions of what issues seemed to be particularly essential to the account, what issues were particularly stressed, what issues were highlighted as being a source of consonance or dissonance for the CHNs and students.

Interpreting the 'parts' and the 'whole'

The combination of interpreting the parts and the whole is a central facet of the interpretive process of phenomenological research. As this study consisted of four

phases this provides another dimension to the phrase 'parts and whole' and the process of integration requires further discussion.

Ramprogus's (1995) report of an analysis method in a multi-phase study was particularly useful. He reports a similar initial process to the other methods already highlighted, followed by a triangulation of the categories from each group. Although referring to grounded theory analysis, Cowley (1991) describes a similar distinction as micro-analysis followed by a meta-analysis working within and across data from all phases of research to gain a deeper understanding of the phenomenon in question. The interpretation of the term meta-analysis, as used in this research requires some discussion. Schreiber, Crooks and Stern (1997) cite Stern and Harris's 1985 definition of meta-analysis as the:

> "synthesis of a group of qualitative research findings into one explanatory interpretive end product." (p312)

They go on to describe current techniques for qualitative meta-analysis as being underdeveloped, lacking clarity and thereby allowing opportunities for creativity. Their own definition of meta-analysis is :

> " ... the aggregating of a group of studies for the purposes of discovering the essential elements and translating the results into an end product that transforms the original results into a new conceptualisation." (p314)

The concept of meta-analysis has therefore been adapted for use in this multi-phase research process in order to facilitate explication of the phenomenon of nursing in a community context. Each phase of the research is therefore both analysed pseudo-independently and as an integrated whole. This approach was developed to

accommodate the concerns raised by Benner, Tanner and Chesla (1996) about entering the hermeneutic circle in the appropriate way:

> "...a way that is shaped by one's grasp of the phenomenon, but at the same time respects the possibilities of the phenomenon showing itself in new ways." (p369)

Each of the four phases could be described as a micro-analysis of the whole process, each phase adding different dimensions of understanding. There was a gradual construction of the multiple dimensions of practice fed by a range of exemplars, each contributing an element of understanding. Northcott (1996) suggests cognitive mapping as one means of developing:

> ... second level meaning without the loss of original construct reality of the respondent..." (p457).

It was only as the many dimensions of practice meaning emerged that linkages between dimensions could be seen more clearly. Detailed accounting of the interpretation trail was therefore extremely important.

These ideas have been particularly influential in this research in relation to data display. Mapping is used to display the development and interrelationship between concepts constructing participants meaning of community nursing. This allowed for review, tracking and challenging of my developing understanding and may be a useful strategy to facilitate dialoguing with the data for the lone researcher.

Researcher / sample participation

As a nurse and educationalist, I did not meet the data in a totally unbiased way. It must therefore be acknowledged that while attempting to disclose the world of community nursing through the eyes of the participants, the outcome is one version.

The process of interpretation is therefore reported in detail to allow the reader to see the origins of significance in the data for the researcher and the participants.

The issue of consensus between researcher and participants requires comment. Some researchers report returning to the research sample for verification purposes i.e. Collaizzi's method. I did return to CHNs and students but to share the data transformation process, rather than for verification. Both student and CHN opinion was sought about the emerging interpretation and to allow for their collaboration. This approach was developed in line with Fielding and Fieldings' (1986) comments:

> "... there is no reason to assume that members have privileged status as commentators on their actions... such feedback cannot be taken as direct validation or refutation of the observers inferences. rather such processes of so called 'validation' should be treated as yet another source of data and insight." (p43)

There is a fine line to be drawn between the role of the collaborative participant and the researcher. According to Koch (1995):

> "Heideggarian hermeneutics locates the unit of analysis in the transaction between participant and interpreter." (p137)

A dialogue between researcher and participant was the aim of this research, but I have to take the ultimate responsibility for the resulting interpretive account and the practicalities of presentation which itself is a form of interpretation.

Returning to the student sample was problematic due to a rapidly changing student population and the participants being within weeks of completing their three year programme. However, discussions were carried out with convenience samples of

students on the ongoing analysis of the research. Returning to the CHN population was much more accessible and they were afforded several opportunities to comment on and contribute to the interpretation as it progressed. The responses were positive in that they reported that I was recounting situations and issues with which they could identify. For example two CHNs said:

> "Why couldn't I say this to you at the beginning, you're saying what I wanted to say but wasn't able to get the words right." [chn 4]

> "This is great, when are you going to start telling people about this, it's what we are about, it really paints a clear picture for someone who doesn't know about us" [chn5]

Summary

After reviewing a range of analytical frameworks the process of interpretation described by Lynch-Sauer (1985) provided guidance for the analytical process. Two levels of 'textual description' and 'textual disclosure' were undertaken in each phase of the research. Van Manen (1990) was influential in the process of theme development undertaken in the research.

Each phase of the research was interpreted as an individual phase, although inevitably always cognisant of the previous phase with a progressive 'mining' for meaning.

Analysis Process: an overview

The purpose of the interpretive exercise is to allow description of the constructs building CHN and student understanding of the experience of nursing in a

community context. Goodman (1978) suggests that much of the activity of 'world making' involves dividing a whole into parts and then building back together again, thereby identifying the inherent features and complexities.

The material for interpretation was generated from the four phases of the research;

- focus groups
- observation with concurrent interviewing
- practice narratives
- narrative discussions.

It must be emphasised that each phase of the research was informed by preceding phases. Accordingly, analysis was undertaken by phase as well as an integrated whole. In line with the combination of perspectives detailed in the theoretical framework discussion, parallel analysis guided by phenomenology and constructivism took place - phenomenology to identify the meaning level and constructivism to build the understanding. The research is intended to explore constructed meaning of practice with the aim of then being able to enhance the educational experience.

I entered into a dialogue with the text, questioning what the data was saying about the meaning of nursing in the community context both in terms of a context for practising nursing and, a context for learning to practice nursing. Dialoguing, according to Koch (1994) is "One of the basic tenets of philosophical hermeneutics..." Each answer provoked further questions and a cyclical, dynamic

process ensued. These questions are included on some of the data diagrams presented in this chapter [identified by *].

It is difficult to define the boundaries between phasal and integrated analysis. The three main stages of the analysis process, construct identification, theme tree development, and interpretive concept development, were informed by all phases of the research. As Benner (1994b) described :

> "When I understood the text from this aspect, I saw these issues and themes but when I began to consider conflicting stories and events and to hear certain arguments within the text, I was able to see new issues and new clearings." (p101)

Initially analysis took the form of identifying constructs in the focus group transcripts. Although a variety of terms are used by researchers i.e. codes, names, categories, constructs was decided upon for this research in keeping with the progressive building or construction process of the interpretation. The activity is best described as identifying components or marking the text rather than entering into detailed interpretive analysis. It lies somewhere between what some authors refer to as coding and what Benner Tanner & Chesla (1996) describe as 'naming'. In preference to coding which they suggest has a scoring implication, they report a 'naming' process which has a greater interpretive component. Anderton et al (1989) caution that such 'categories' do not need to be seen as 'concrete' and can change as analysis progresses. Acknowledging this potential and in line with the openness and receptiveness of hermeneutical interpretation, analysis was a dynamic process. Webs of potential meanings were developed in the early stages of the interpretive process. These allowed me to return to audit meaning emergence. Interpretations

were therefore identified, clarified and developed as the analysis progressed. A similar experience is recounted by Allen and Jenson (1990) :

> "It was an intense intellectual process with each reading bringing new insights which helped clarify and refine understanding." (p247)

Each phase of data collection is explored in more detail in the following sections of this chapter. Extracts from the data are provided to support the interpretive process. One of the concepts which emerged as significant during the process was that of 'risk and uncertainty'. The emergence of this concept is tracked during each phase of the analysis process to provide a detailed example of concept development (Tables 6, 7, 9 and Figures 20, 22, 24).

Focus Groups

The data generated from the focus groups were analysed by participant group i.e. CHN and student. This was done to allow the meaning of practice held by each group to be both identified and compared.

Figure 13 presents a map of the focus group analysis process.

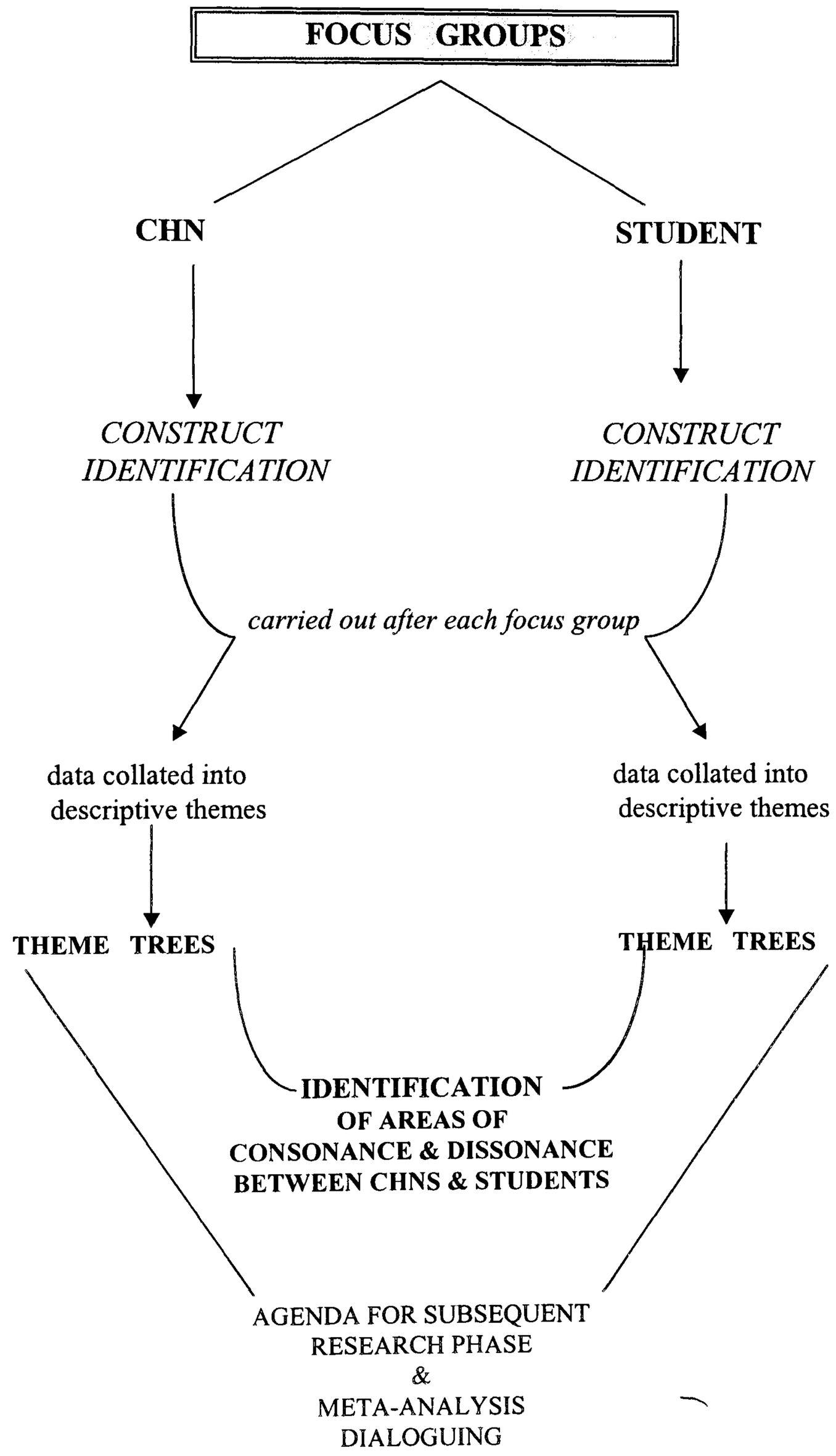


Figure 13 Focus group analysis map

The interview tapes were transcribed in full by the researcher. This began the process of developing familiarity with the data. The micro-level structural analysis process was then carried out by reading the transcripts to identify constructs. Construct labels were generally words or phrases taken directly from the data. Tables 5 and 6 illustrate how some constructs were identified from CHN and student focus groups. The aim at this point in the analysis was weighted towards description rather than explanation.

Table 5 Construct identification process: student focus groups

Student Focus Group Transcripts	**Constructs**
I didn't really learn any new skills, just to be neater	*learning agenda/ clinical skills*
Sometimes it's obvious but I get the impression she [chn] knows alot	*learning agenda/ breadth of knowledge*
There isn't alot to learn, it's all very routine	*learning agenda/ routine*
Communication is more honest, different to hospital	*communication community is different*
Patients open up and divulge so much, you felt sucked in	*communications/ relationship with patient/ no escape from pts*
She cared for so many different types of patient, diabetic, terminal, surgical	*things that impressed/ clinical skills/*
They seem to notice an awful lot	*seeing things/ things that impressed*
You are on your own, you can't turn round and ask someone if you are stuck	*on your own/ decision making*

Table 6 Construct identification process: CHN focus groups

CHN Focus Group Transcripts	Construct
It's difficult to get down to their level and remember what it was like to be that inexperienced	*levels of practice/ experience*
I don't think students appreciate that it's your patient for ever	*aims of practice/ relationship with pts*
You negotiate with every patient, how much they want to do, what personal space is needed - you are in someone's home after all - students don't appreciate the negotiation	*underlying negotiations/ relationship with pts/ aims of practice*
Patients are selective in what they share with students	*selective practice*
Students need to come to terms with how people live	*reality*
Routine may turn out not to be routine	*routine/ unexpected*
Community is about the unexpected, things you can't always plan for - and you deal with it alone	*unexpected/ on your own*
It's sometimes hard to articulate why we are different to students - we are but it's hard to spell out	*appreciation of role/ difficult things to teach*
In community you have to make decisions there and then, you can't go away and ask someone - it feels different	*time constraints/ on your own/ decision making*
Students don't appreciate all the layers of practice	*levels of practice/ difficult things to teach*
Taking the job as a set of tasks its quite simple, but it's so much more than that	*levels of practice*
We pick up on underlying things they [students] don't see	*digging deeper*
Hospital is such a protected environment	*different to hospital/ unexpected*

Construct identification was most intensive when analysing the first focus groups. Subsequent transcripts generally added content to constructs rather than many additional constructs. This occurred despite care having been taken not to guide the respondents to these constructs during subsequent focus groups. It is perhaps worth noting that because of my reticence to become too involved in the data production during the focus groups, the constructs presented were generated by the participants rather than in response to researcher interventions to reorient the discussion. This is an important point in relation to the phenomenological philosophy of the research. Although I have declared my participation in 'mining the meaning' of practice, the material from which to 'mine' is generated by the participants.

Twenty two constructs were identified from the CHN group and sixteen from the student group. They are presented in Table 7, the order of presentation is not intended to hold any significance. Some comments were duplicated under more than one heading to avoid premature closure of interpretation.

Table 7 Focus Group Constructs

CHN Focus Group Constructs	Student Focus Group Constructs
Relationship with patients	Relationship with patients
Selective practice	Community knowledge
Time constraints	No escape from patient
Difficult things to teach	Learning agenda
Levels of practice	Breadth of knowledge
Underlying negotiations	No-one to check with
Aims of practice	Focus of care
Things students find difficult to learn	Confidence
Clinical skills	Clinical skills
Routine	Routine
Seeing things	Seeing things
Communication	Communication
Different to hospital	Community is different
You're on your own	Alone
Reality	Things that impressed me
Essential skills	Grading
Grading	
Experience	
Appreciation of role	
Digging deeper	
Unexpected	
Decision making	

Several of the constructs were identified by both groups for example, *routine, learning agenda, communication, being alone, environment of care* . However, although they may share the same building blocks of meaning, their interpretation of the value, importance and complexity of the constructs differed.

One striking difference was in relation to the *routine* construct. CHNs used the term to suggest that their practice could be differentiated into the aspects students could cope with, the routine, and those aspects which were unexpected and unpredictable with which they considered students could not cope. The students however, generally used the term 'routine' to convey their perception that the majority of community practice was routine, with connotations of not demanding, not critical, predictable.

The construct of *learning agenda* also had different meanings for students and CHNs. Students generally reported that the learning agenda was rather obvious to them. On the contrary CHNs identified issues that were difficult for students to learn and aspects of practice which students did not appear to perceive, such as 'seeing things' and 'unexpectedness'.

There was a level of consensus in several constructs. For example, both groups agreed that practising alone was significant and that communication was different

and more 'real' or 'honest' in community compared to the hospital setting. Although there was some commonality with respect to *environment of care,* the CHN construct was much more complex.

The analysis proceeded with further reading of the transcripts and integrative networking between constructs. As a consequence it was possible to regroup the constructs under theme headings. They are presented in Table 8. All the original data was retained and systematically stored as a precaution against losing something that I may have been blind to at any stage in the analysis process.

Table 8 CHN and Student Theme Tree Headings

THEME TREE HEADINGS	
CHN	**STUDENT**
PRACTICE AGENDA	PRACTICE AGENDA
ENVIRONMENT OF CARE	ENVIRONMENT OF CARE
DECISION MAKING	DECISION MAKING
DIFFERENCES BETWEEN CHNS & STUDENTS	DIFFERENCES BETWEEN STUDENTS & CHNS
ON YOUR OWN	RESPONSIBILITY
LEARNING/TEACHING OPPORTUNITIES	LEARNING OPPORTUNITIES
LEVELS OF PRACTICE	SKILLS FOR COMMUNITY PRACTICE
COMMUNICATION	COMMUNICATION
TIME-SCALE	

Themes were developed as theme trees to both display and retain data detail. This presentation style also provided a visual impact of the theme complexity. The

development process of a theme tree is presented in Figure 14, tracing the process from transcript quotes which developed into constructs and then theme tree branches and theme trees.

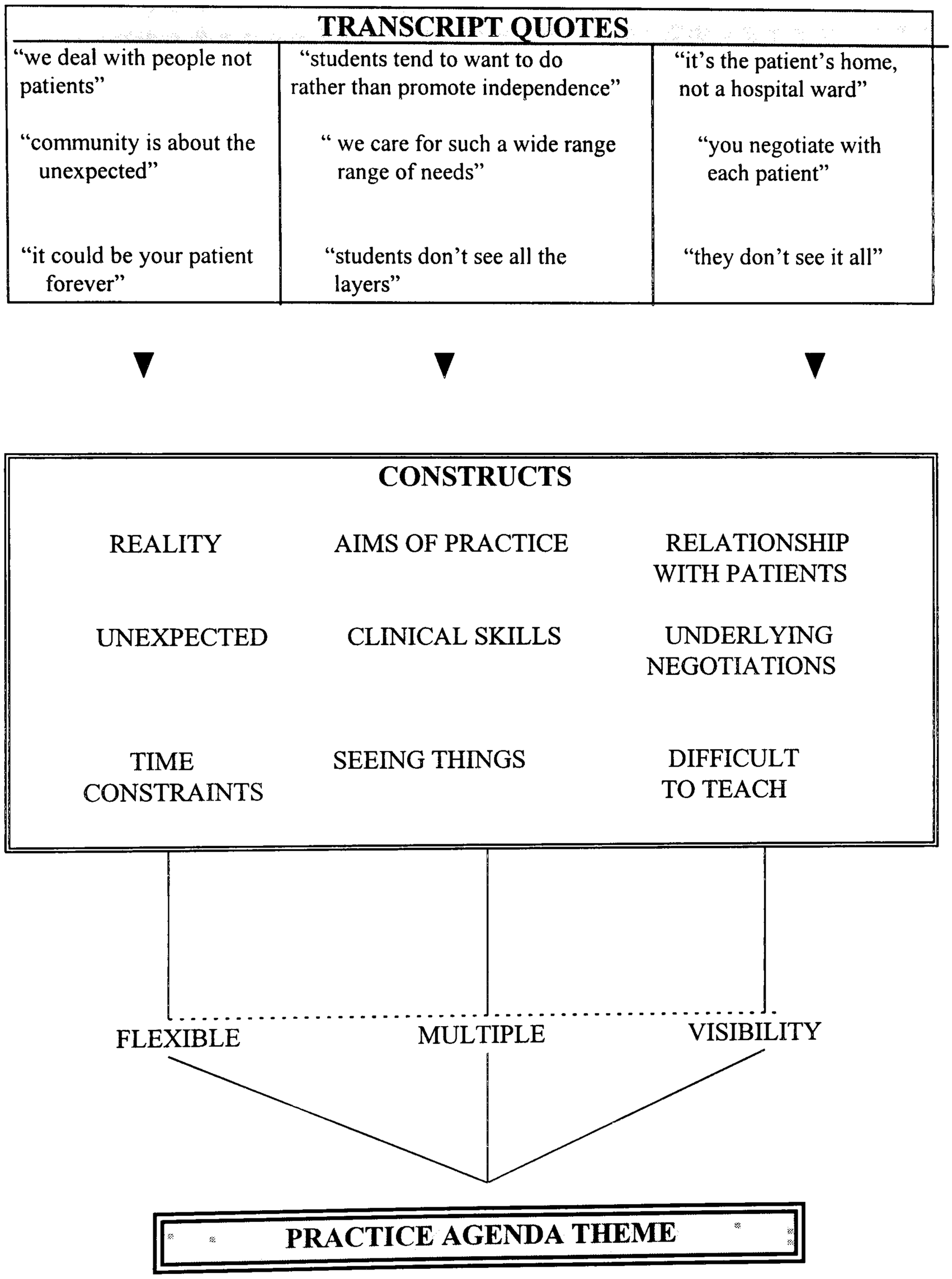


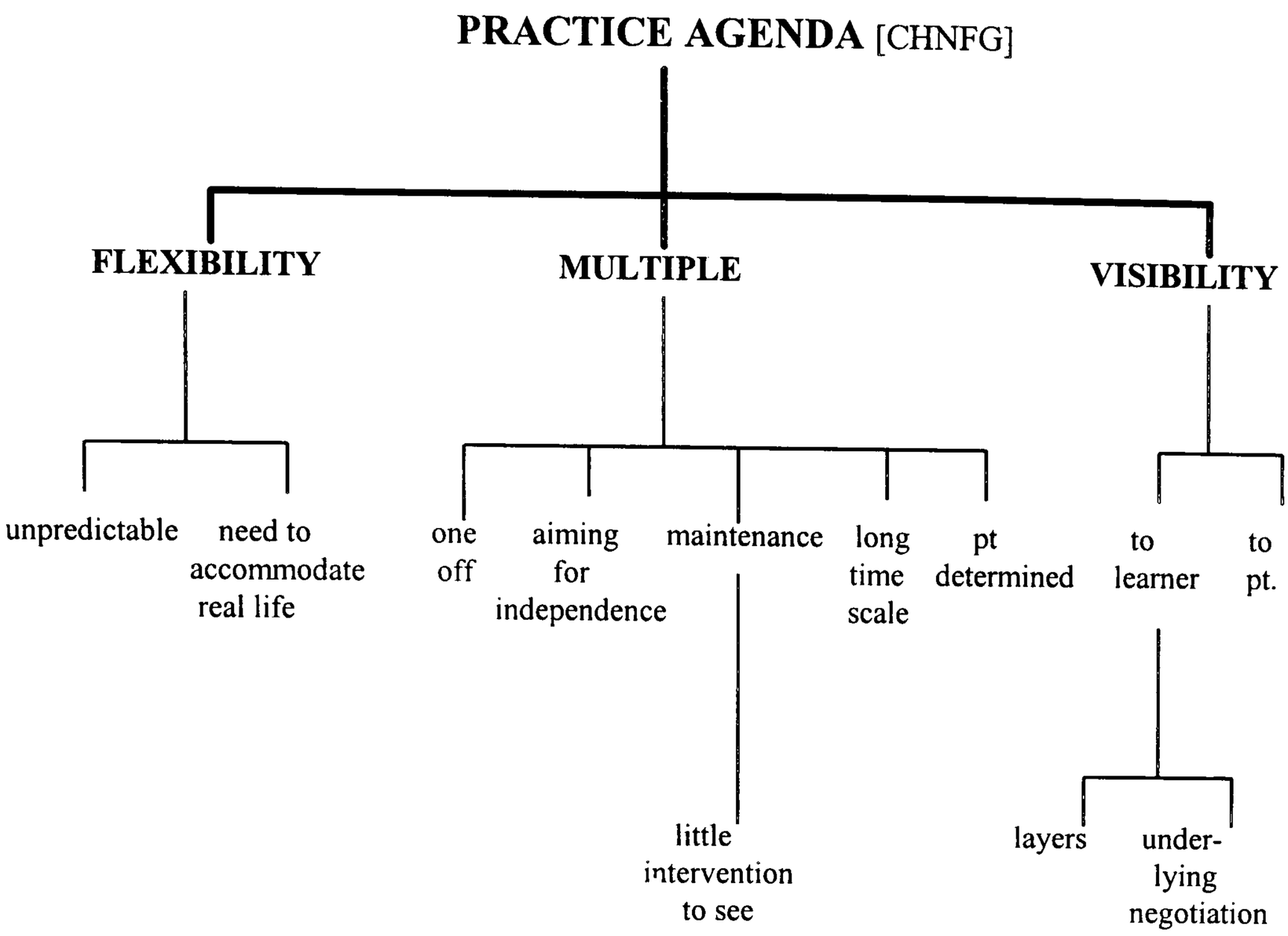
Figure 14 Practice agenda theme development process

Figures 15 to 18 give examples of the next stage in the data analysis and display process showing practice agenda and environment of care theme trees. Meta-analysis memos [*] are also included as an example of how dialoguing with the text occurred. These notes allowed me to record interpretive concept development and the identification of significant issues. More examples of theme trees are presented in Appendix 8.

Theme tree comparisons were made on a number of levels:

- themes
- theme tree branches
- theme tree complexity

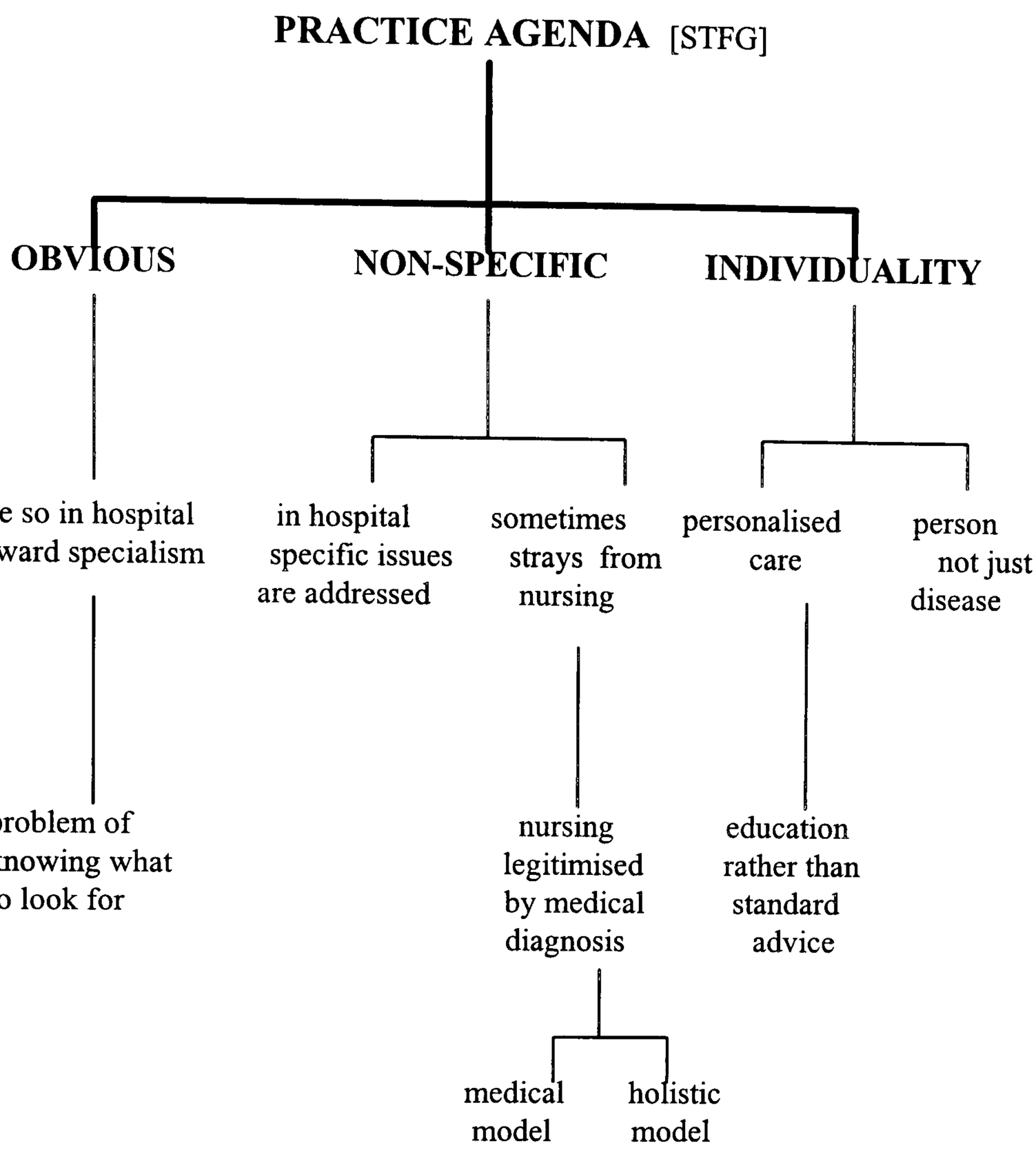
Not surprisingly, CHN trees were more detailed and complex than those of students. It is to be expected that those people immersed in the role will have developed a more detailed construction.



* why is it unpredictable, can 'it' not be assessed
* what impact does 'real life' have on nursing practice ?
* time scale of care can be very variable - potential relationship issues
* how does the pt determine the agenda - does this have a link with predictability issue
* why is practice so invisible to students - do CHNs not share this detail ?
* visibility is also implicated in the type of care i.e. maintenance/little intervention- what definition of intervention is being used - ? task related

Figure 15 CHN 'Practice Agenda' Theme Tree

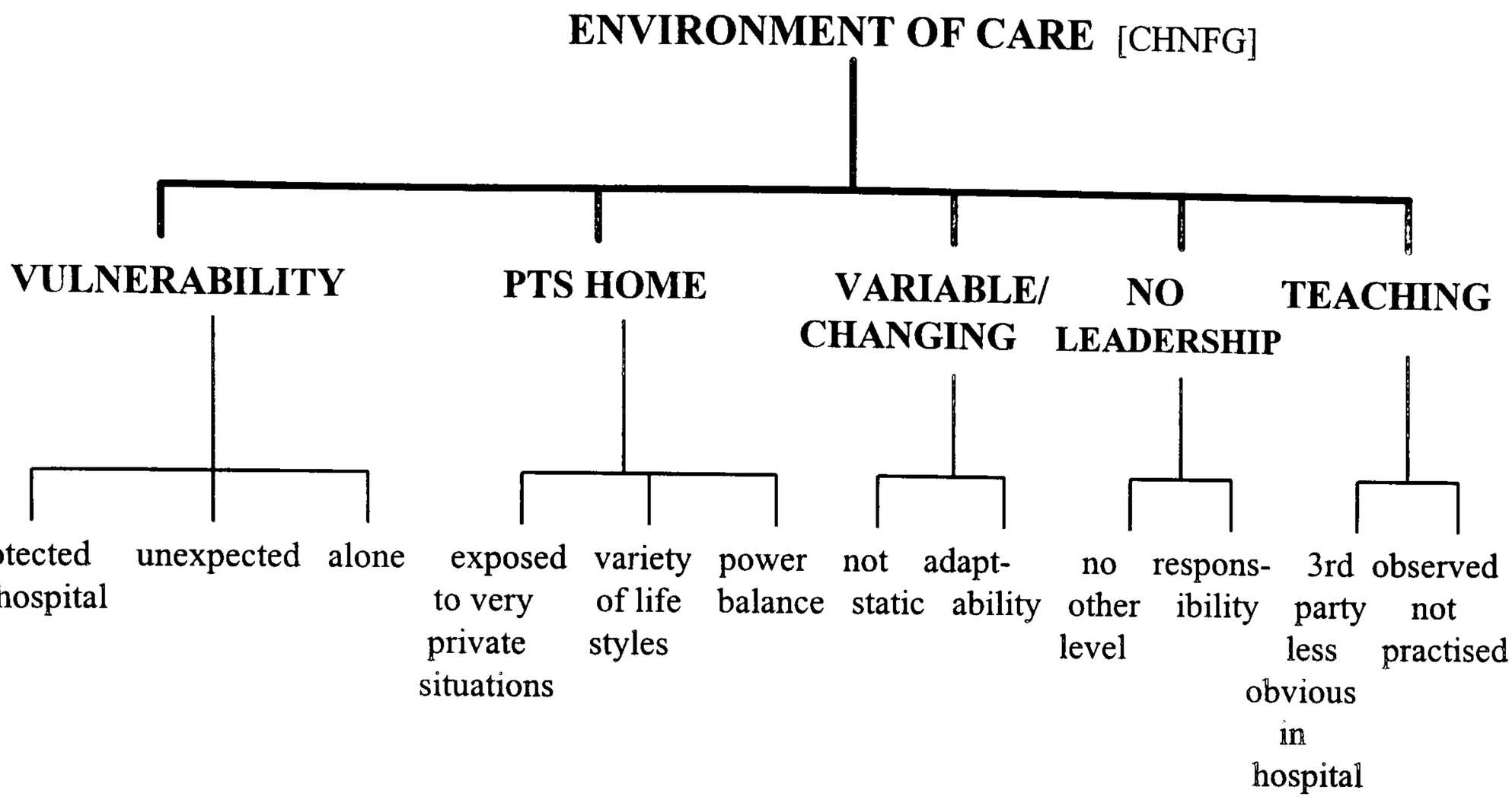
[CHNFG] = Community Health Nurse Focus Group



* students appear to be struggling to see the totality of practice, the usual labels for hospital context are not adequate to direct their learning ?
* students appear to question whether some of the CHN work is really nursing, they appear more comfortable with medical definitions of care
* individuality and tailored care is seen as a contrast to other experiences and appears to be admired

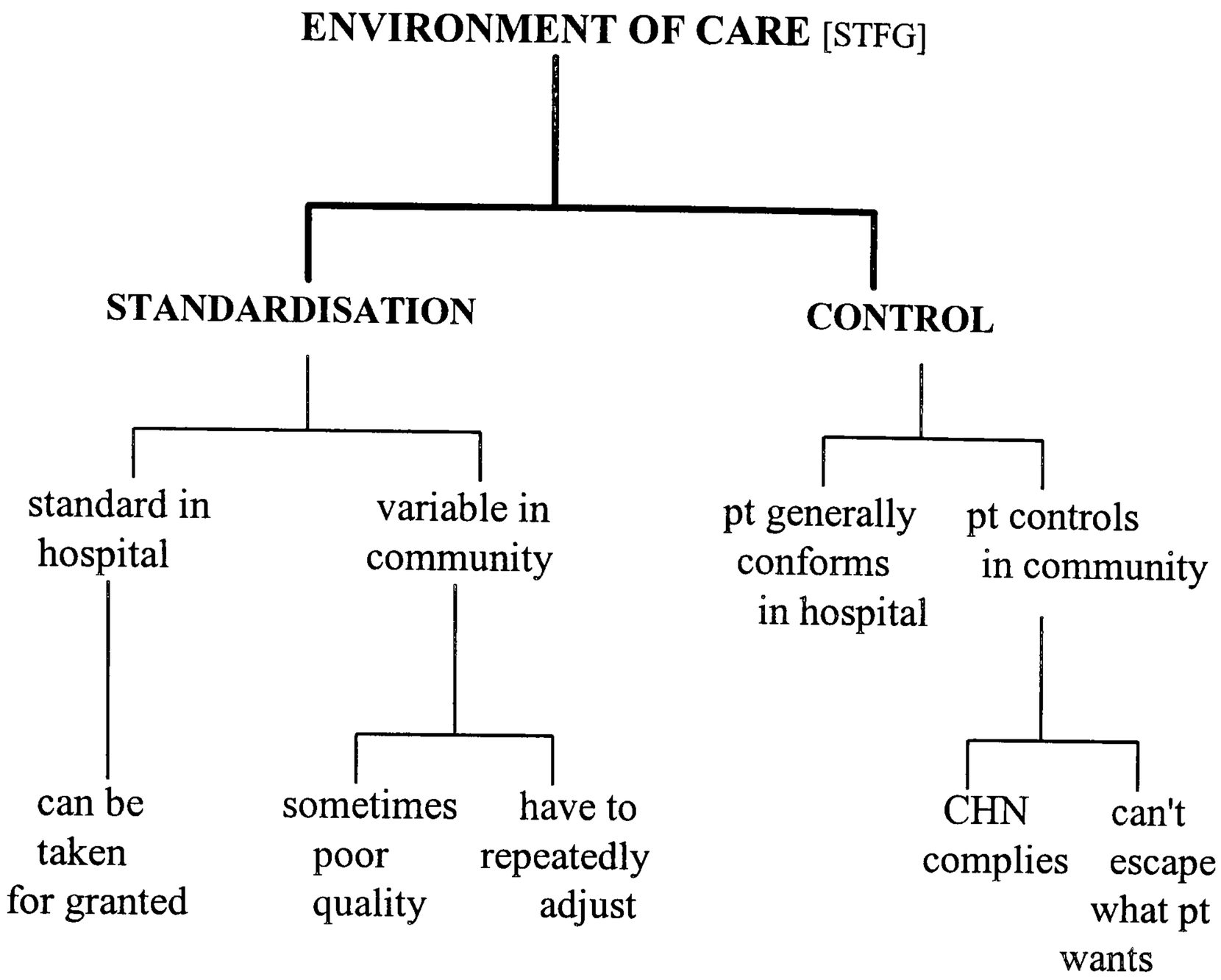
Figure 16 Student 'Practice Agenda' Theme Tree

[STFG] = Student Focus Group



* what types of events are unexpected ?
* what are you protected from in hospital, but exposed to in community ?
* what are the implications for being alone, why do CHNs experience vulnerability as a consequence?
* practising in the patients home exposes CHN to private situations - does CHN then have to become involved - does this impinge of nurse/patient relationship - is it affected by time-scale
* the power balance is affected by care being delivered in the patients home, what impact does this have on the experience of nursing for CHNS?
* care environment often changes - is this as aspect of unexpected. What does the nurse have to adapt to ?
* CHNs appear to be very aware that their usual dyad relationship becomes a triad when a student is present. Why should being obvious be an issue - this related to power balance and pts home
* CHNs appear to be very aware that students rarely practice community nursing, they usually accompany a CHN and observe/assist. What implications does this have ?

Figure 17 CHN 'Environment of Care' Theme Tree



* there appears to be an additional layer of assessment in the community the environment has to be considered, whereas in hospital it does not require consideration
* 'adjust' needs to be explored - have students picked up on the underlying negotiations CHNs referred to in practice agenda tree ?
* hospital environment is seen to be one where professional has the greatest level of control. Control in what sense - what impact does level of control have ?
* sts don't seem to have experienced the negotiations CHNs refer to in practice agenda tree, students seem to perceive CHNs as complying rather than negotiating with patients - could me scale be relevant i.e. students don't see whole negotiation process ?
* 'escape' gives a sense of feeling trapped or controlled by patient. Do patients need/request different things than patients in hospital or is it the escape element that is more possible in hospital ?

Figure 18 Student 'Environment of Care' Theme Tree

Areas of consonance and dissonance identified by comparison of all theme trees for CHNs and students are summarised in Figure 19.

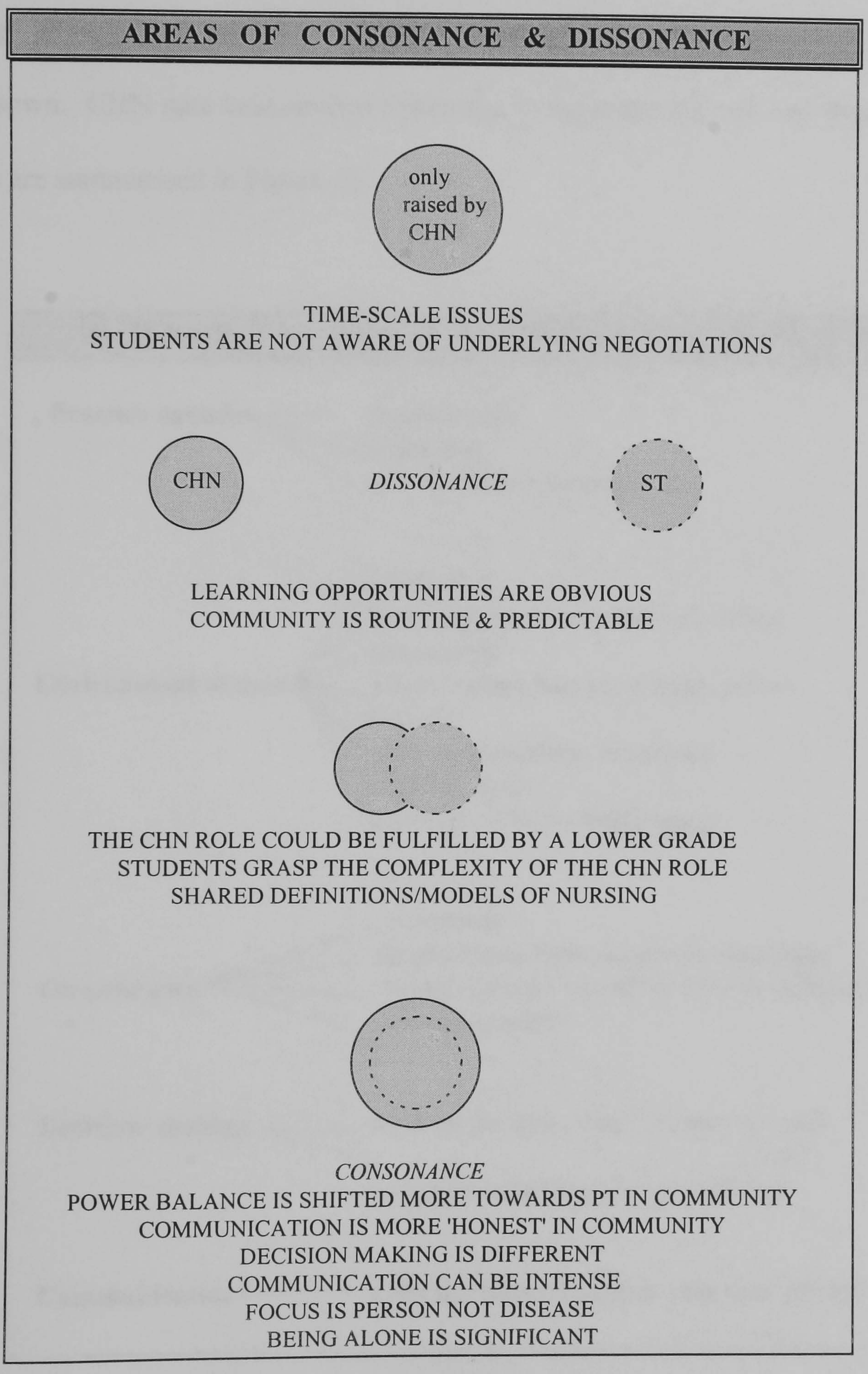


Figure 19 Areas of dissonance and consonance between CHNs and students

As stated earlier emergence of the concept of risk /uncertainty is tracked during each phase of the analysis process as a means of demonstrating concept development. On completion of the focus group analysis, the risk/uncertainty concept had not been explicitly identified. However, the seeds of its emergence had been sown. CHN data held several references to experiencing risk and uncertainty. These are summarised in Figure 20.

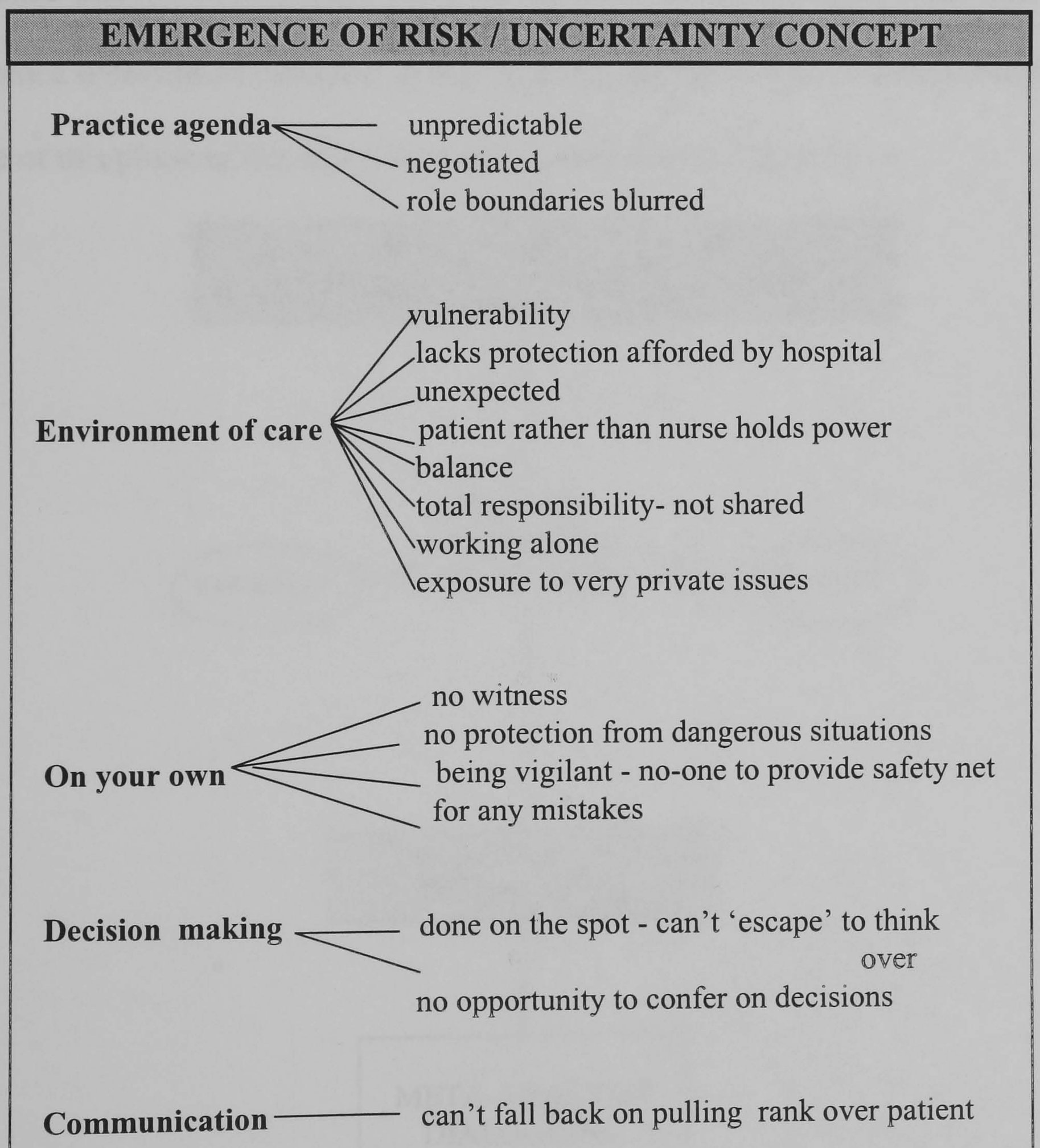


Figure 20 Emergence of the risk/uncertainty concept

The total relevance and linkage between some of these constructs and themes was not apparent at this stage. To use a phenomenological term, much of the meaning was still transparent to both researcher and participants. The level of understanding at this stage was very web-like and concepts could not yet be constructed.

Observation with concurrent interviewing

This phase had two data sources. One was the interview tapes and the other was the experience reflections I recorded in the hours immediately after the observations.

A map of this phase of the analysis process is provided in Figure 21 .

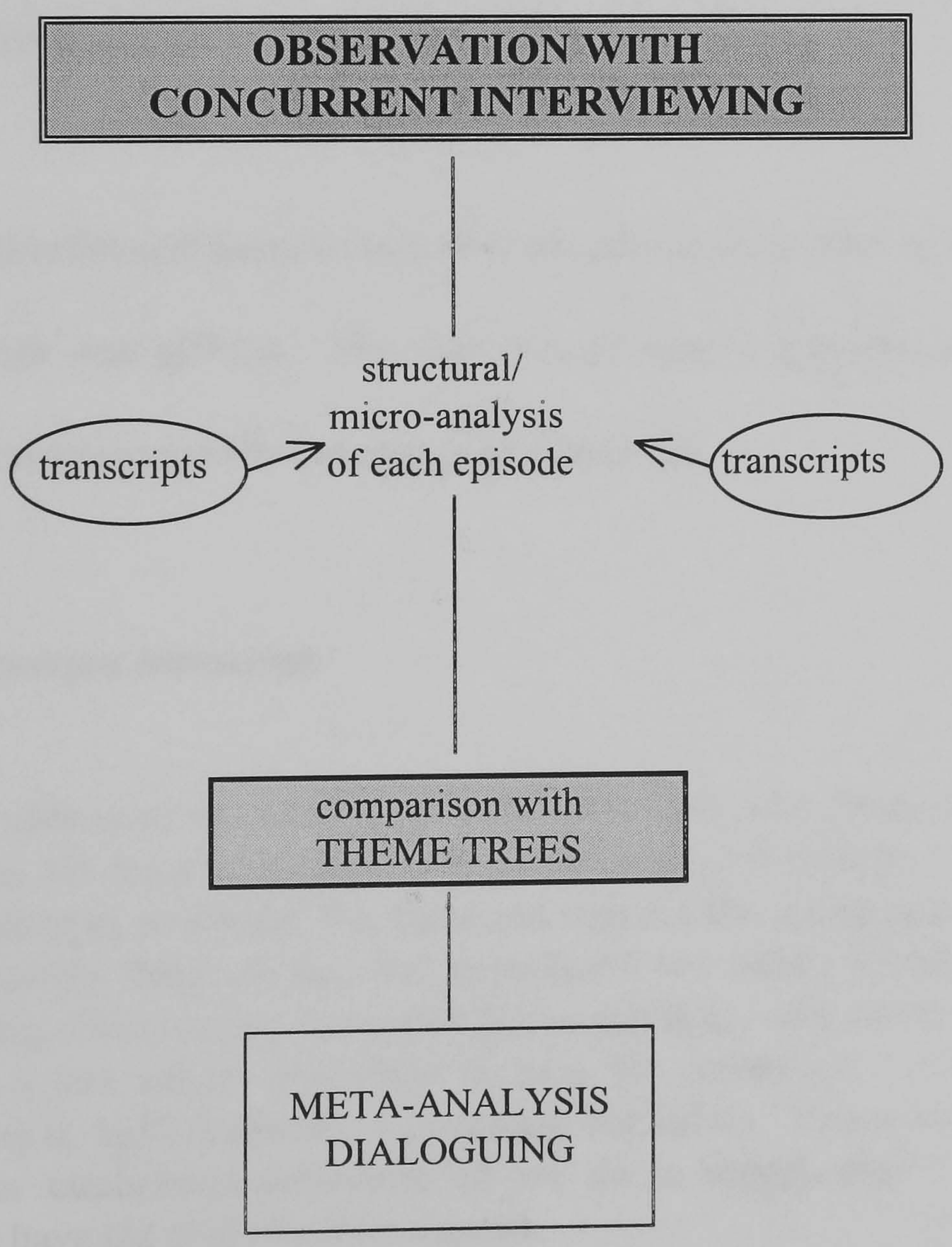


Figure 21 Observation phase analysis map

Again interview tapes were transcribed by the researcher. Transcripts were read and construct and theme issues noted and compared to phase one analysis. This added depth or additional perspectives to some trees. Little addition was made to some trees, although this was not necessarily seen as a comment on their overall relevance, but the type of issue accessed by this data collection method.

My reflective accounts, incident notes and the relevant sections of transcripts were used to construct a map of all or part of a visit. This is an example of the influence of the constructivist framework on the analysis process. The components of the visit were then compared to theme trees and examples of themes identified. This mapping tool is demonstrated in Figures 22 and 23.

The transcript and reflection notes of one visit are provided in order to demonstrate how the framework was utilised. The visit was chosen to continue to allow the emergence of the risk/uncertainty concept to be displayed.

The pre-visit discussion transcript:

> CHN
> The next visit is to an elderly, virtually blind lady who lives alone. I've visited her for a while now and get on quite well with her. She has a number of problems, but the main reasons I'm going in today are to generally check on her, and specifically see what's happening with her legs because she has a circulation problem - she sleeps in a chair not a bed which does little to help the circulation - I keep mentioning it, but I doubt she will change her habits. I also want to review her continence problems, all we do is supply pads - she refuses to have the problem investigated.
>
> SMC [researcher]
> Do you know the reason for the refusal ?

CHN
No... it's not very satisfactory, but I can't force her to do something she doesn't want to can I ? At least things are better than when I first started visiting, she used newspapers to control the flow then - so we have moved on a bit ! She has a variety of carers going in - home care, the nursing auxiliary, and a neighbour is good, although I worry about the set up at times

SMC
What worries you ?

CHN
Well, I think the neighbour is an alcoholic or at least drinks heavily - I worry about her reliability - she's quite a significant part of this lady's support system and I feel I can't really rely on her 100% - even without the drink thing she is only a neighbour - the care she provides is out of the goodness of her heart - she's not obliged to. Mind you I do sometimes wonder if she uses some of Mrs.A's tranquilliser prescription.

SMC
What makes you think that?

CHN
Nothing specific, just she sometimes seems to go through a lot and then at other times the script seems to last longer. I don't know really - it's just something I wonder about.

Observation notes:

The door of the flat was open ready for us and the CHN shouted a greeting as we entered. Once in the living room she informed the patient of my presence and requested her permission for me to observe the visit. Readily given. The lady was cheerful and chatty. She was sitting in a chair, the same chair she slept in. The CHN sat down and checked the condition of the patients legs. She stressed the benefit of keeping the legs raised and advised the lady of the disadvantages of sleeping in a chair. The patient did not respond to this specific issue but asked the CHN how long it was before her holiday and were her children looking forward to it.
The CHN asked about continence and went into another room to check the supply of pads. When she left me in the room with this virtually blind stranger I felt rather ill at ease, more for the patient than for myself i.e. that she was left with a stranger who she did not know and could not see. I therefore made idle chat about the weather and how interesting it was spending the day with the CHN.
The CHN busied herself around this lady's home going from one room to another. After checking her pad supply in the bedroom she

went into the kitchen, at the patients request, to check on medication stocks and that the water heater was switched on ready for a bath later that day with which the neighbour was going to assist.

The CHN confirmed who would be visiting the patient over the next few days and who would be covering her during her holiday leave. The patient suggested the CHN left the door ajar ready for the next visitor, but the CHN declined and went back into the living room to stress that it was ill advised to leave the door unlocked.

Post ~ visit transcript:

CHN
That really worries me, leaving the door ajar, its not the best area of the city, you don't know who gets to know about her and she is so trusting - the house is often full of waifs and strays - I'm not sure what kind of social life or groups she mixed with when she was more able I sometimes wonder if she was a bit of a drinker - there's some weird people in there sometimes. I sometimes feel like checking to see who they are and that she does actually know them and want them there, but then I think - really is it anything to do with me - I don't know really - if something goes wrong with her then no doubt it would have been something to do with me ! Seriously though she wouldn't manage if it wasn't for the array of people calling in and out - she would be very lonely without them - so in some ways they're a godsend.
Did you notice I went on about raising the legs again - she ignored me and talked about my holiday instead, but I feel obliged to keep trying with her, although I'm fairly sure she won't change her sleeping arrangements. She seemed quite well today and well organised, sometimes I have to chivvy her about medication and prescriptions but she's on the ball just now.
I think students sometimes wonder what it's all about when you are running around checking the immersion heater is on - but in community you can't divorce one need from another - I couldn't just go in there and do 'nursing' things - I have to care for the whole person in their surroundings - in community we fit in with **them,** not them with us - that's something students find difficult I think, that we don't rule the roost like in hospital - in hospital the ward has an agenda and the patients fit into **it,** not out here - there's some of my patients I have to arrange visits to fit in with their bingo afternoons - not when I think is the most appropriate time for the dressing or whatever it is, but when it fits in with the rest of their life.

SMC
There's obviously a lot of things going on concurrently with that lady, the circulation problem and the sleeping issue, the continence, maintaining a level of independence, safety, the reliability of the neighbour - how do students appreciate all those issues ?

CHN
They don't - if it's a short placement I don't go into all the details - I can't back track on everyone's history every time I take a student in - it's just too much. Sometimes the student just has to take the visit as it stands - I tell them a bit of the story, but not everything - we don't have time for one thing.

SMC
So does that mean that some students could come away from that experience understanding that your role is to check the lady's skin condition and check the incontinence pad stock ?

CHN
Well yes I suppose some could - especially when I'm very busy and we have little time to talk between visits - when I think about it there's so much going on in there and its been going on for such a long time and I'll probably continue to visit her for god knows how long - it's too long a tale - may be I should write a book !

SMC
I think the timescale of your involvement might be an important issue nothing was really concluded today ...

CHN
Nothing ever seems to be concluded with that lady, it's always **continuing,** keeping her going, gently persuading, monitoring, watching and waiting in case something goes wrong ...

SMC
What do you mean ' something goes wrong' ?

CHN
Oh, it could be many things, she falls, she has an accident, the neighbour and friends don't bother for some reason, the neighbour is on the drink and does take her medication, that she leaves the door open and goodness knows who goes in, she becomes uncooperative, my relationship hasn't always been so good - it took some persuading for her to accept incontinence pads .... I just feel I have to be alert to potential problems.

Discussion was concluded at this point because we had arrived at the next visit.

The content of the visit, as I perceived it was detailed in my reflective notes. The 'notes' are a combination of mental jottings to discuss with the CHN after the visit, and other notes written during the observation day (during the lunch break, in the evening). This was part of the 'mining for meaning' process.

Questions / issues

* The patient chose not to respond to the CHNs comments about sleeping position. Presumably the comments were regularly ignored but the CHN persisted in making them- was this an example of **underlying negotiations ?**

* The CHN was not very forceful, it really seemed that the **patient had control -** if the whole care plan had not been explained in detail and the history and potential future of the care explained I could have perceived the CHN to allowed the patient to dictate the process and appear not to challenge. Back again to the issue of **visibility** of practice.

* **Time scale** is important - there's a long history to this care situation - students only see a snap shot - and probably rarely see results - does this cause them to close off to some aspects or do they see these aspects/ **layers -** do the CHNs share them- is it such a complex situation that they don't unravel it completely for the student ?

* What would the student actually **see** or get out of that visit - could be reduced to bare activities and some of them did not appear to demand great nursing skill - although the skill in being

accepted by the patient, trusted and allowed to go around someone's home may not be highlighted

* Sleeping in a chair is not the 'norm', yet we just accepted that this was how this lady chooses to behave - norms appear to be disregarded somewhat - CHNs appear to **accept** how the patient lives - what would happen in hospital - would the nurse 'allow' this patient to sleep in the chair all night or would this be unacceptable. How far do the 'limits' or acceptability stretch ?

* The CHN felt very uneasy about non-specific problems - there were lost of **'maybes'** - the support system may collapse, there may be something going on with the neighbour and medication .... its very nebulous, but a cause of anxiety and concern to the CHN

* What exactly is the CHN role ? - should she intervene in the way this patient wished to live her life i.e. leaving door unlocked, allowing 'waifs and strays' into her home - she feels considerable **uncertainty**. This appears to be an example of something raised in the focus groups - you are exposed to the detail of patients lives and patients expose alot about themselves to you - that can cause confusion or debate about how much of this information the CHN should acknowledge and how much is not her business

* The context was **unpredictable,** the CHN said that she did not know who would be in the house when she visited and she did not know whether the patient would be safe or would have fallen etc.This must be an element of practice that hospital based staff do not engage in - what about A&E - they don't know what is coming in through the doors - but - they are not **alone**

* Does the student fully engage in the experience. Although only observing I felt very much an extra to the situation and was very evident especially when the CHN went out of the room - I was a visitor in the relationship and the ongoing care - do students feel like that - does that keep them at a distance and is that why they don't **see** all the layers of practice - do they have to? If you are only observing and/or accompanying - can you ever appreciate what this monitoring and uncertainty feels like ?

Similar transcripts were developed for all the observations carried out during the research. This vast amount of data had to be managed in some way in order to access it and to allow comparison and meta- analysis dialoguing within and across the four phases of the research. The visit content map was therefore developed as a method of analysis, storage and presentation. Some of the information in these transcripts and notes is presented in visit content maps in Figures 22 and 23 on the following pages.

ENVIRONMENT OF CARE EXPOSES CHN TO OTHER LIFESTYLE ISSUES

PRACTICE AGENDA

PATIENT CONTROL ISSUE - CHOOSES NOT TO COMPLY WITH SLEEPING POSITION ADVISE

NURSE/PATIENT POWER BALANCE

One aspect of visit to single, blind lady approx. 65 years was to check leg skin integrity & circulation. Patient always slept in armchair not bed. A significant amount of informal care was provided by neighbour (thought to be alcoholic and possibly using patients tranquilliser medication) and wide range of 'waifs and strays'

CHN UNCERTAIN IF SHE SHOULD INTERVENE

UNCERTAINTY / PRACTICE AGENDA

CHN IS CONCERNED THAT PATIENT MAY BE 'AT RISK'

UNCERTAINTY / RISK

SITUATION MONITORED OVER PERIOD OF TIME

TIME SCALE

Figure 22 Observation visit content map

PRACTICE AGENDA WAS NEGOTIATED WITH THE PATIENT - MORE TO HER SATISFACTION THAN CHNS

PRACTICE AGENDA NEGOTIATION

POWER BALANCE WEIGHTED MORE TOWARDS PATIENT & CHN DOES NOT APPEAR TO CHALLENGE

NEGOTIATION / TIME-SCALE

One purpose of a visit was to monitor continence problem.

Patient had refused to have cause investigated - but wanted problem managed to her satisfaction

MODEL DRIVING PRACTICE COMBINES TREATMENT/CURE FOCUS & COPING

NORMALISING COPING/ MANAGING

VISIT SHOWED ME THE END PRODUCT OF NEGOTIATION NOT THE PROCESS

VISIBILITY

THE CARE RELATIONSHIP HAD A LONG HISTORY & WAS CONTINUING

TIME-SCALE

Figure 23 Observation visit map

The themes presented in Table 9 appeared to have particular relevance in the CHNs meaning construction as it was articulated during the observation phase of the research. *Normalising* was the only new theme to be developed, although it had aspects in common with other issues related to accepting patients lifestyles and practising in the real, as opposed to the more contrived world of the hospital. The other themes had already been identified from the previous phase.

Table 9 Themes central to CHN meaning construction

THEME	FACETS
PRACTICE AGENDA	* *visibility of practice* * *parameters of practice* * *perceptions of practice* * *negotiated practice*
NURSE/PATIENT POWER BALANCE	* *sharing care*
VISIBILITY	* *hidden agendas* * *role visibility*
TIME SCALE	* *long term & short term relationships* * *impact of practice*
LEARNING	* *hospital & community comparison* * *role parameters* * *things CHNs identify as difficult to learn* * *vicarious learning*
ROUTINE	
DYAD RELATIONSHIP	
BEING ALONE	
UNCERTAINTY	
NORMALISING / ACCEPTING	

Meta-analytic dialoguing was more evident in this phase of the interpretive process. The inter-relationship between some themes was becoming more apparent. A number of explanatory concepts were emerging. They had characteristics of frequency and having links between themes. This is illustrated by returning to the concept of risk and uncertainty. This concept appeared to represent the integration of several facets of practice constructions.

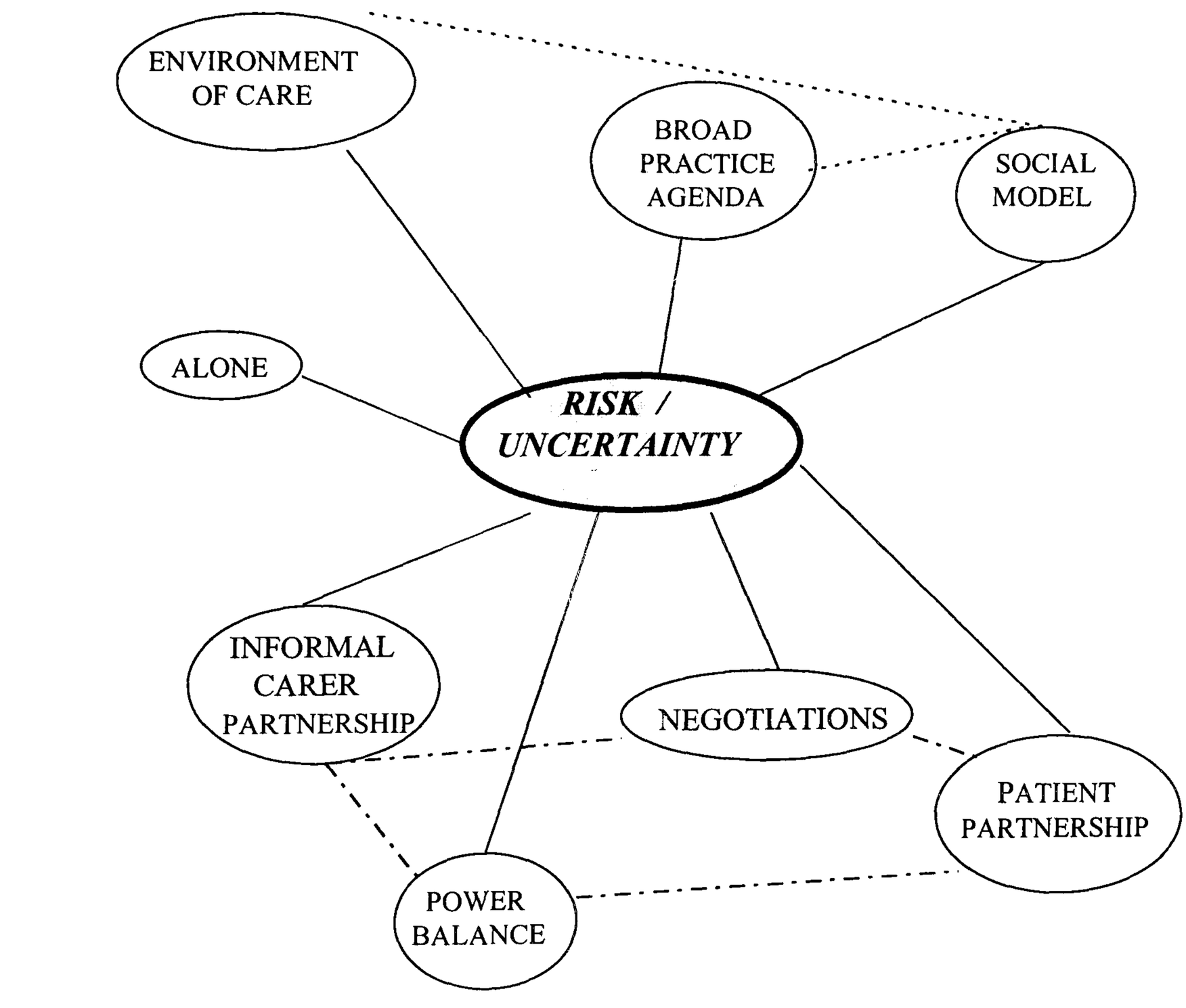


Figure 24 Themes informing the concept of risk/uncertainty and inter-theme links

Practice Narratives

Although not collected concurrent to the activity, the narratives were recorded very soon after the experience had taken place. A level of retrospection had therefore inevitably occurred. However, the narratives still provided a means of accessing the framework used by CHNs and students to describe and to make sense of their nursing experiences. This is in keeping with what Schon (1987) describes as the process of practitioners naming what they notice in a situation, what they select for attention and how they organise the experience. Comparison of the CHN and student tapes therefore allowed the 'naming and framing' distinctions of the two groups to be identified. The narratives were interpreted as a means of reflecting how the participants experienced the world. The level of accuracy or 'correctness' was not an issue, individual reflections were accepted without judgement.

Practice narratives of the same visit provided by CHNs and students were transcribed. Transcriptions were stored in pairs. Initial structural analysis was performed with constructs as meaning units. However, in this phase the intention was not to access closed construct discussion, but to access an account of the lived experience in which constructs were not necessarily explicitly stated. It was the task of the researcher to continue to 'mine' the meaning construction of the experience. For example when a CHN was talking about how she was maintaining a relationship with patients, the **time-scale** theme was identified by the researcher as being implicit in the narrative. Another example would be a CHN debating whether to take some information at face value or whether she should investigate

further, the themes of **digging deeper** and **uncertainty** were identified by the researcher.

A template, presented in Figure 25 was developed to manage the data from this phase of the research. Fish, Twinn and Purr (1991) report dissatisfaction with their initial attempts to analyse student/supervisor debriefing dialogues using a 'reductionist instrument' with set categories in which the researchers attempted to place all dialogue. They subsequently developed a guide based on four strands of reflection. Factual, retrospective, substratum and connective (reference was made to these strands in the earlier discussion on practice narrative discussion development). Although unavoidably reductionist to some extent, the templates I developed imposed limited structure and manipulation on the data i.e. no set categories were used, but acted as a format for chronological reconstruction of the CHN or student description of their experience. Implicit or explicit theme tree references were subsequently noted.

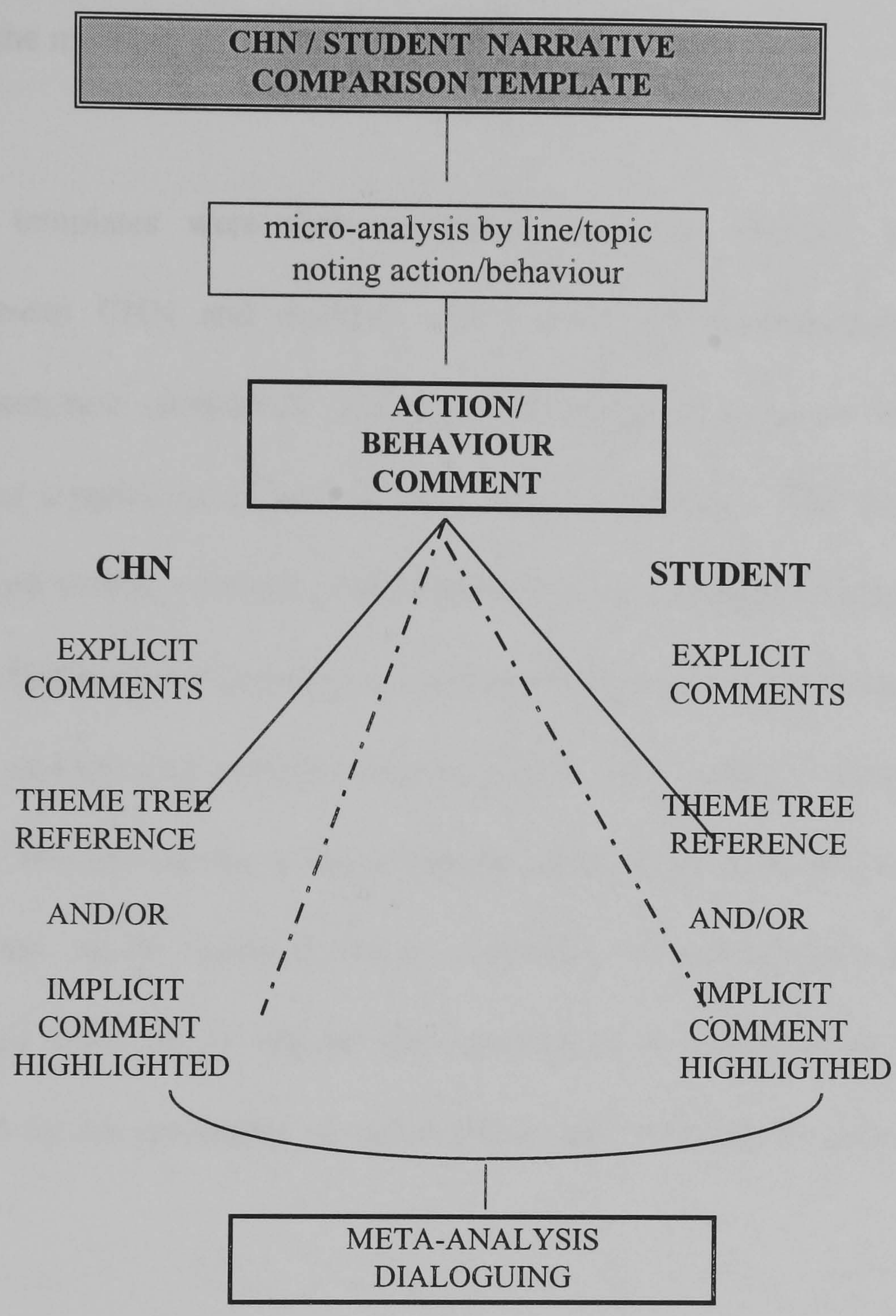


Figure 25 Narrative comparison template

Each transcript of the pair was initially analysed independently. The transcripts were broken down in a similar vein to the other micro-analysis already carried out in other phases. However, constructs were not the only recording unit. A more open perspective to recording was adopted. As each action, behaviour, comment was identified by the CHN or the student it was noted and questions asked :

- does this comment relate to/ contribute to/ contradict add anything to any of the theme trees ?

- is this statement implicitly making a meaningful comment which needs further exploration ?

- what is the meaning in this description ?

The individual templates were then combined onto one template to allow comparison between CHN and student. This facilitated development of the dissonance /consonance comparison and an opportunity to question why each individual painted a particular picture of the clinical experience. This moved the meta-analysis work further with the confirmation and development of explanatory categories which had been developing over previous phases. It is significant to note that the 'naming and framing' options of the narratives were totally in the hands of the participants. The dimensions of the experience they chose to record were their decisions. For this reason, endorsement or expansion of explanatory categories already developed from earlier phases was interpreted as confirmation that the meanings evoked for the researcher in earlier phases had meaning for practitioners and students.

The narratives were very much targeted at the 'knowing that' form of knowledge, attempting to access a phenomenological understanding of 'being-in-the-world' of community nursing. The narratives were based on 'typical' experiences i.e. participants were asked to record whatever they met with during the recording period and were not to try to capture a 'different' or 'critical' experience, although they could include such incidents if they wished.

Although narrative skill varied between participants, CHN narratives were more complex, as would be expected. CHNs and students tended overall to identify the same events within each visit. However, the difference lay in their interpretation or response. Students responses were often more closed than the CHN and they generally adopted a more task orientation. This may be an endorsement of Cowley's (1993a) work in relation to skill mix and the different levels of decision making which take place in practice. Specifically, she quotes Vaughan (1991)

> "It is not the task which matters. It is the level of decision making that goes on during the activity which determines whether a qualified nurses' skills come into play."
> (Cowley 1993:167)

Three examples of completed templates are presented in Figures 26 to 28 in the following pages. Each template is provided by a different CHN/student pair and is accompanied by a brief explanatory discussion. The templates identify what appeared to be salient issues in the narrative of the practice experience and allow consonance and dissonance between CHN and student to be identified. The narratives presented here relate to older patients. Although the full adult age spectrum was represented in the narratives, the older client group did predominate. It is important to note however, that the age of the patient did not appear to be a significant variable in that no additional themes or constructs were raised with patients from other age groups.

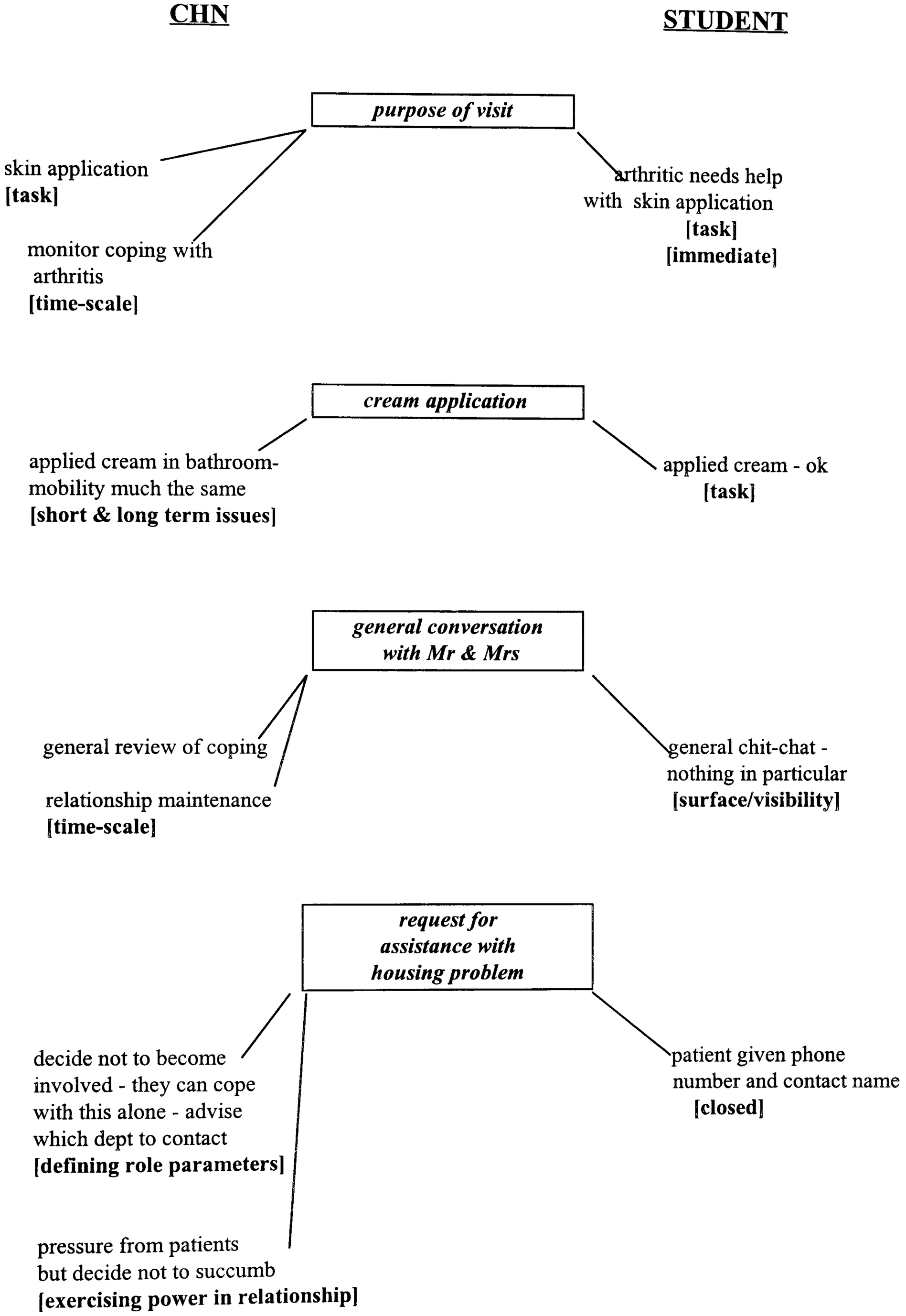


Figure 26 Practice narrative template

Figure 26 is a template of one of the shorter narratives. However, despite it's briefness a number of issues were highlighted which develop understanding of how each participant understands their experience.

The CHN had a long standing relationship with this family. Mrs X was the primary client, suffering with arthritis and consequent pain and mobility problems. Her husband, also retired, was the prime carer and therefore also received 'monitoring' attention with respect to his general well-being and ability to cope. Superimposed on this long standing problem was a more acute skin problem, which because of the patients arthritis required CHN intervention to apply the prescribed treatment.

Both CHN and student identify the **task** element to the visit. They immediately differ in relation to time-scale, where the student appears to have an immediate perspective and the CHN is setting this encounter into a wider time frame.

These same issues are further demonstrated in the next area of discussion, 'cream application'.

The CHN then engaged in conversation with Mr and Mrs X in order to review how they are coping and to maintain their ongoing relationship. **Time-scale** again predominates. In contrast the student had a very **surface** interpretation of this activity, i.e. it was seen simply as a general conversation. The rationale and process of the conversation were not **visible** to the student.

The final aspect of the narrative is also rich in meaning. The student again takes a **superficial,** obvious perspective. She summarises the interaction in a very 'closed' way. The CHN discusses a self-debating process in which she works at defining her **role parameters.** She identifies that she feels that the clients are trying to pressurise her into acting to their definition of her role. However, the patient/nurse **power balance** issue is raised in that the CHN decided not to 'succumb' and remain faithful to her definition of her role.

Figure 27 illustrates a range of issues. Firstly the **'multi-purpose'** nature of the practice. Although it had been assumed that the content of the visit could have been reasonably well anticipated, this narrative provides an example of the importance of remaining flexible and receptive to new issues.

The student adopts a very technical **task** approach to dealing with the smell of urine in the home. The incident is also dealt with in a rather **closed** manner. In contrast the CHN tried to explore the situation by **'digging deeper'.** Overall, the CHN is prepared to review the assessment of clients needs and to use a range of information including **'peripheral issues'** This contrasts with the student who appears to not be prepared to deviate very far from the original visit agenda.

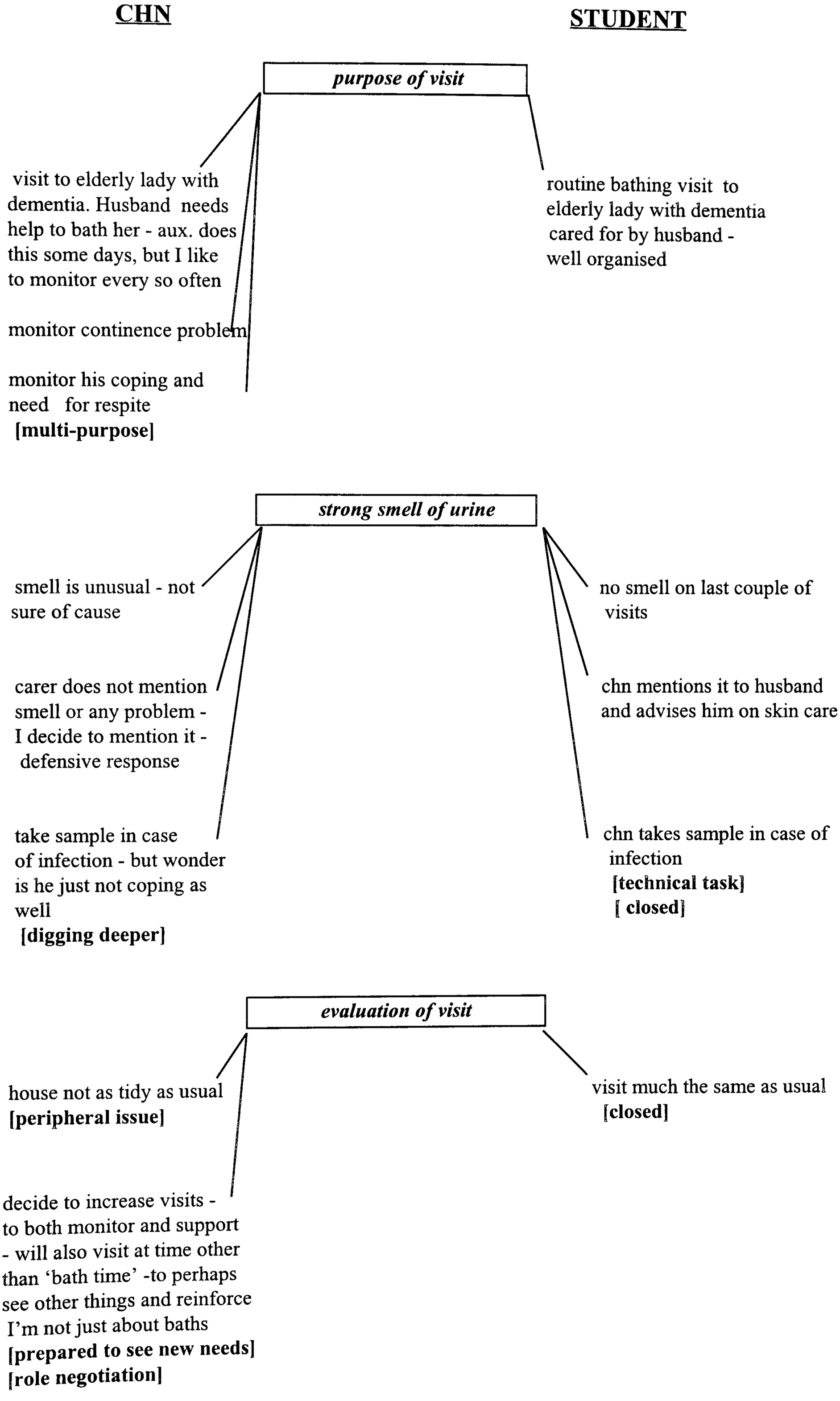


Figure 27 Practice narrative template

Several issues are met again in Figure 28 which related to a non-specific referral to an elderly lady whose family had reported to the GP that 'she was not coping'. **Time scale, technical focus, closed approach** are again evident. This example also highlights the difference in how student and CHN perceive 'legitimate' nursing which is strongly influenced by perceptions of the **social model** of health and care. Linked to the **time-scale** concept is the CHNs discussion of how she planned to perpetuate the contact with the client using 'passport activities'.

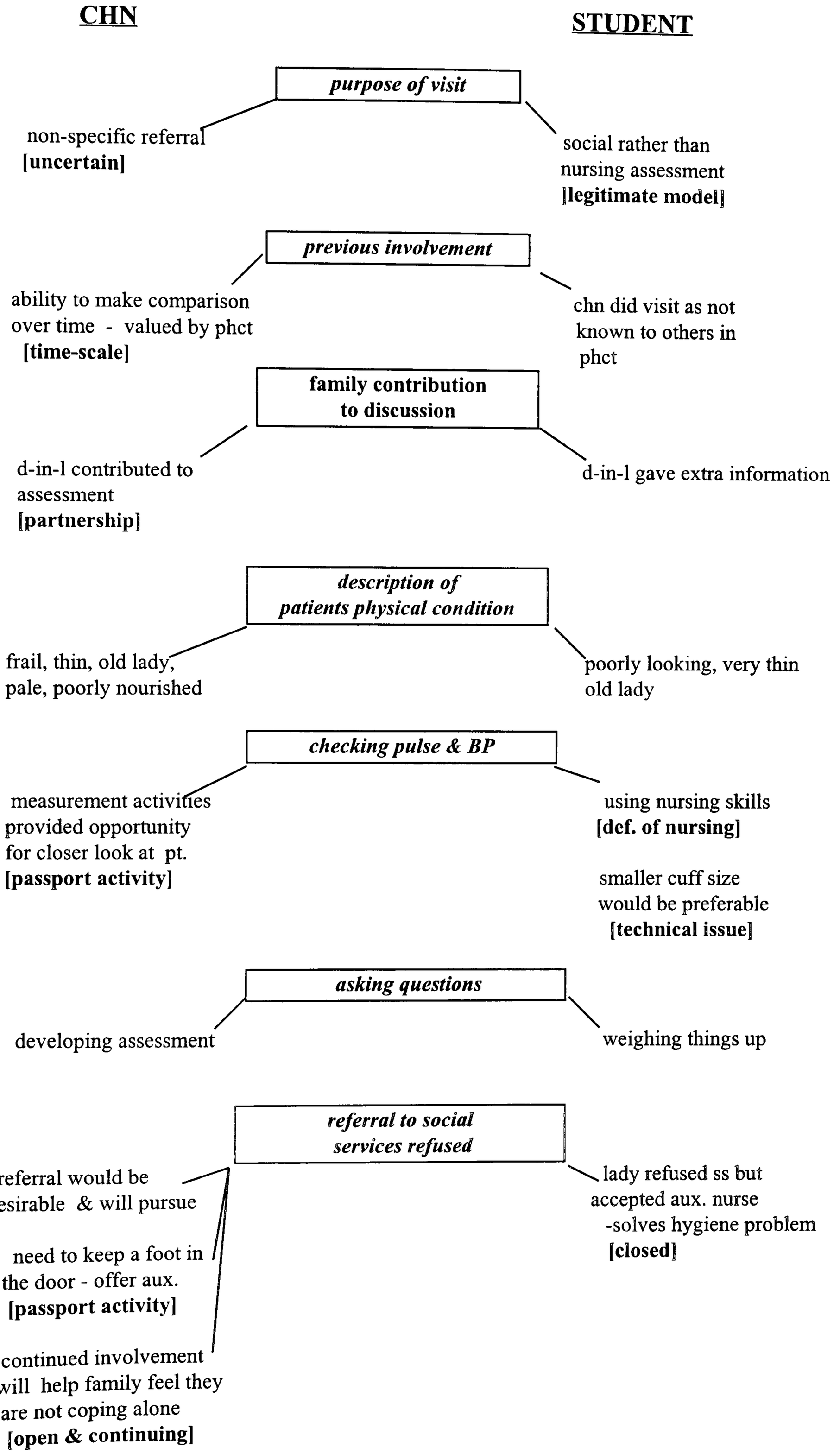


Figure 28 Practice narrative template

Three template examples were provided for two reasons. Firstly each template provided a slightly different perspective. Secondly, although they are provided by different student/CHN pairs, read concurrently they could describe a typical 2-3 hour period in a CHN day. They provide actual examples of the range of patient care situations students referred to early on in the research. The templates also illustrate the complex, diverse and changing practice and learning environment of community nursing practice.

Narrative Discussions

This phase had a twofold intent. One was to further develop the 'texture' of the interpretation. The other focused on validation or more accurately the 'trustworthiness' or 'confirmability' of the data and interpretation. In other words, the purpose was not to seek verification of the narratives, but confirmation that they and the meanings interpreted from them, were honest representations of community nursing. The purpose of the discussion was therefore to gain assistance in painting a real life and recognisable picture. This was in line with the overriding phenomenological philosophy of the research. As Anderson (1991) says:

> "One should bear in mind that the purpose of phenomenology is to describe the lived experience of people. Methods of data analysis that fragment the lived experience may distort that which it seeks to describe." (p35)

CHN and student paired transcripts were presented to small groups of CHNs. They recorded individual comments on the transcripts and general group discussion was tape recorded and later transcribed by the researcher.

Most of the participants appeared to enjoy discussing examples of practice and what practice meant for them. Luker and Kendrick (1992) perhaps shed some light on the reason for this reaction that community practice is :

"largely invisible and they rarely have the opportunity for peer review."

They appeared to value the opportunity to receive endorsement that 'someone else feels like me' .

There was consistency between CHNs in the issues they highlighted and comments made on the transcripts during the discussion. There was also considerable empathy between CHNs when discussing the narratives. This suggested that they were 'typical' of community nursing practice, of student /CHN distinctions and practice learning/teaching issues.

The reactions from CHNs also reinforced the value of narrative comparisons in practice articulation and learning. The CHNs were surprised at the 'version' of practice reported by some students, especially that described in Figure 26. Having said that, they were not critical of the student for having developed this interpretation. On the contrary, they reported to have achieved a new level of appreciation of the level of articulation required to adequately show students the detail of practice and thereby allow student and CHN to have a more shared version of their reality.

The narrative discussions reinforced that the community as an 'environment of care', held a number of consequences for practising nursing and teaching/learning nursing

in this context. The concepts of 'being alone', 'risk and uncertainty', 'time-scale' issues, problems with practice 'visibility' and the diverse and negotiated 'practice agenda' were endorsed as being crucial to the meaning of practice in the community context and further examples and dimensions were added during the discussions.

Issues of rigour in the research process

The value of assessing the reliability and validity of qualitative research is questionable. These evaluation criteria serve positivist research, but are not the most relevant criteria for qualitative work. Hallett (1995b) suggests that rigour in this type of research can be judged in terms of data relevance and representation of participants' views.

Sandelowski (1993) addresses a number of issues in this debate. Qualitative researchers may be at risk of not being true to their research paradigm if inappropriately using criteria of rigour drawn from a different and incompatible paradigm. She attacks too close an adherence to positivist criteria saying :

> "It is as if, in our quasi-militaristic zeal to neutralize bias and defend our projects against threats to validity, we were more preoccupied with building fortifications against attack than creating the evocative, true-to-life, and meaningful portraits, stories and landscapes of human experience that constitute the best test of rigour in qualitative work." (p1)

Returning to the research sample for verification during the interpretive process is also a debated issue. For example, it is an identified stage in Colaizzi and Van Kaam's analysis models. However, seeking validity in this way must be considered

with caution in relation to the interpretive paradigm. Sandelowski (1993) stresses that one of the tenets of interpretive research is that :

> "...reality is assumed to be multiple and constructed rather than singular and tangible." (p3)

Hallett (1995b) reports that she did not return to her sample for judgement on her paraphrasing of the data. Alternatively she presents sufficient raw data in her report for the reader to make a judgement on her interpretation, acknowledging that others may 'see' different things.

There were three reasons for returning to the sample at various stages during this research; confirmability, professional etiquette, and the notion of 'fusion of horizons'. Both research participants and small groups from subsequent cohorts of students (contributing students left the programme very soon after data collection) were given verbal summaries on the progress of the research and interpretations. They were able to confirm that the analysis 'made sense to them' and reflected aspects of their experience of living in the world of community nursing. According to Oilier (1982) the appropriate test of validity for qualitative research is that the findings are "recognised as true by those who had the experience".

The research has also been reported at an international community nursing conference (see Appendix 9). The interpretations received an enthusiastic response, with participants from both the UK and noticeably Sweden recognising the issues identified and described.

A number of indicators therefore suggest that a level of trustworthiness has been achieved in this study. Firstly, the interpretations are those of the researcher at a particular point in time and they have been received by members of the community nursing world as recognisable descriptions for them. Secondly, the process of interpreting the data is reported in detail to allow reader scrutiny, meeting Sandelowski's (1993) definition of trustworthiness :

> "...a matter of persuasion whereby the scientist is viewed as having made those practices visible and therefore auditable." (p2)

Summary : analysis and interpretation

Although presented chronologically here in order to enhance clarity and auditability, analysis was a dynamic, iterative process. It had much in common with Mcleod's (1990) aim:

> "not to reduce the data to pieces and subsequently reassemble them but rather to come to an ever richer understanding of the parts and the whole." (p78)

Similarly, Koch (1994) refers to a "fusing of all sources of data". This study accessed data using a variety of approaches and participants. Data were not simply aggregated in this study, but the process drew on constructivist philosophy during both the collection and interpretation phases to develop a multi-dimensional understanding. As Thompson (1990) says :

> "A final outcome of the fusion of horizons then is that understanding results in an ever-increasing openness, for hermeneutic experiences always enlarge and enrich our understanding of the human condition." (p247)

Deliberations about where the analysis process should end were put into perspective by Darwin's (1869) comments:

> "If I lived twenty more years and was able to work, how I should have to modify the Origin, and how much the views on all points will have to be modified ! Well it is a beginning, and that is something ..." (Wolcott 1990:5)

Accordingly, the level of analysis achieved is acknowledged to be at some point along a potential continuum. The need to share research in an area where there is such a deficit, together with the demands of the academic process guided the decision to halt analysis at this point. Repeated returning to the CHN sample has encouraged me to believe that the core meanings of community nursing practice, according to this sample have been accessed. Data reduction has inevitably taken place and another researcher looking through different lens may see a different version. However, according to Sandelowski (1993) "good qualitative data reduction grabs the 'essence' of the phenomena" and I believe this has been achieved.

Bousefield (1997) describes phenomenological analysis as a journey through samples of significant phases to a final synthesis that 'elaborates lived experience'. In relation to this study it was probably possible to 'read' the analysis map in a number of ways, certain pathways were taken and a destination has been reached. No doubt other destinations with different angles on this phenomenon would have been reached if different paths had been taken. This is a characteristic of the interpretive philosophy.

Figure 29 presents the core meaning components which have been constructed from analysing the experience of community nursing as reported by this particular group of CHNs and student nurses.

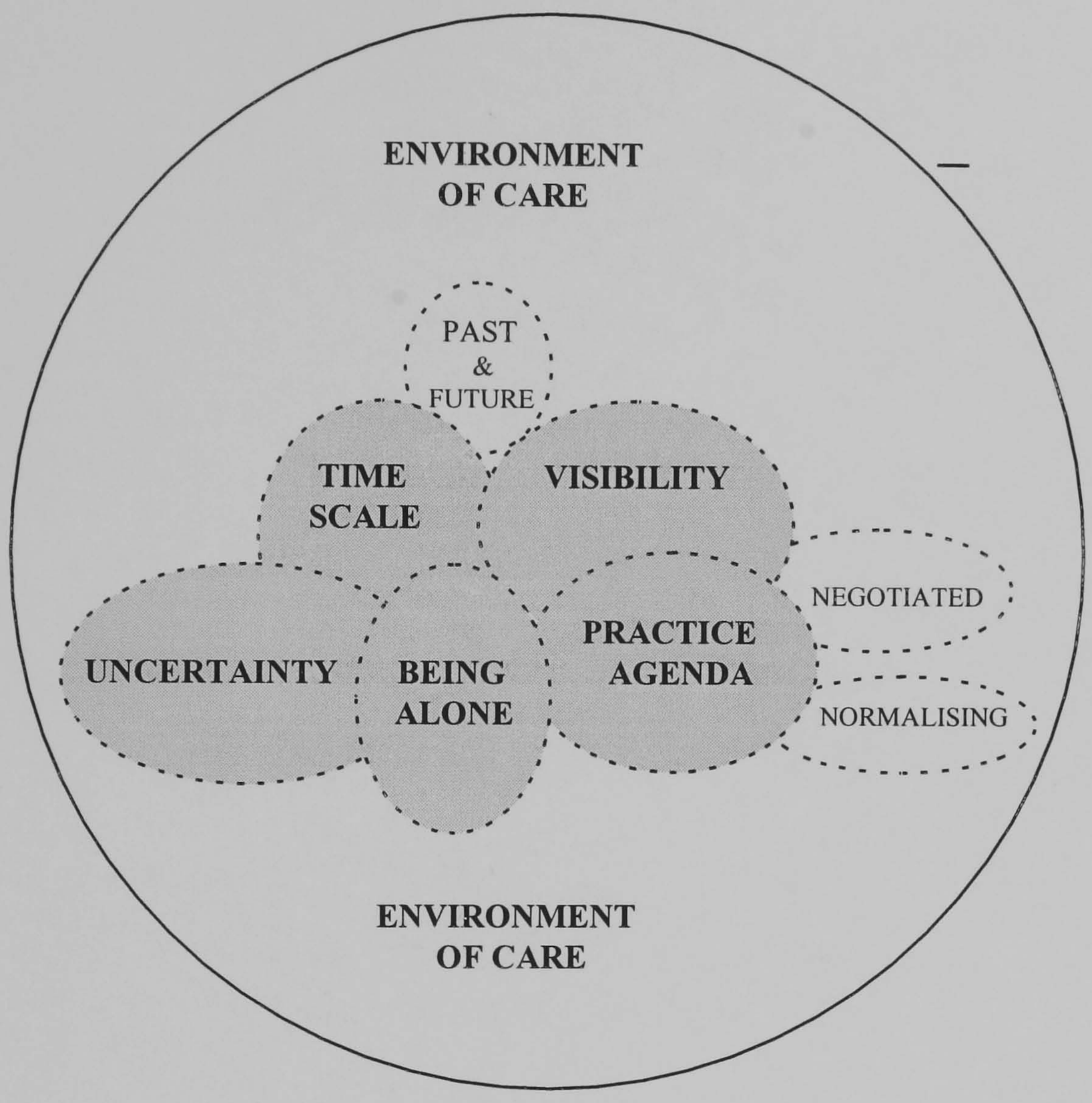


Figure 29 Concepts building the constructed meaning of community nursing

These concepts appear to provide a framework for understanding the phenomenon of community as a context for practising and learning to practice nursing. The context of practice is highly significant and so '**environment of care**' is a core issue which has implications for all other dimensions. The five core concepts of '**practice agenda**' , '**uncertainty**', '**time-scale**', '**being-alone**' , and '**visibility**'

each have a number of foci and are therefore interrelated in a number of ways. **'Negotiation'**, **'normalising'** and **'past and future'** are not identified as central concepts but contribute strongly to the constructed meaning. The content of Figure 29 is explored in detail in the next chapters.

CHAPTER 6

MEANINGS & INTERPRETATIONS

Introduction

Draper (1990) suggests that nursing would benefit from the development of descriptive theories that actually identify those phenomena which 'count as nursing'. It is the intention of this research and specifically this chapter, to provide some organising framework for understanding nursing practice in a community context. As a consequence, the educational features should also be more readily located, contributing to a practice relevant curriculum.

This chapter develops the discussion presented in the previous chapter by accessing another interpretive level that further unravels the meaning of practice as expressed by this group of students and community nurses. In doing so, it is responding to calls to make the detail of practice more explicit. For example, Cowley (1993a) draws attention to the problem of "important aspects of the work of community nurses are implicit, so cannot be readily explained." This has health service policy and education implications.

This research revealed several overlapping strands which appear to contribute significantly to shaping understanding of practice in the community. The environment of care has a major impact on practice and learning. This reinforces the concerns expressed by, for example Kenyon (1990), that the context of nursing practice has not been afforded sufficient regard in nurse education curricula. Within the broad theme of environment of care five explanatory concepts have been identified. Each concept has a number of dimensions as detailed in Figure 30.

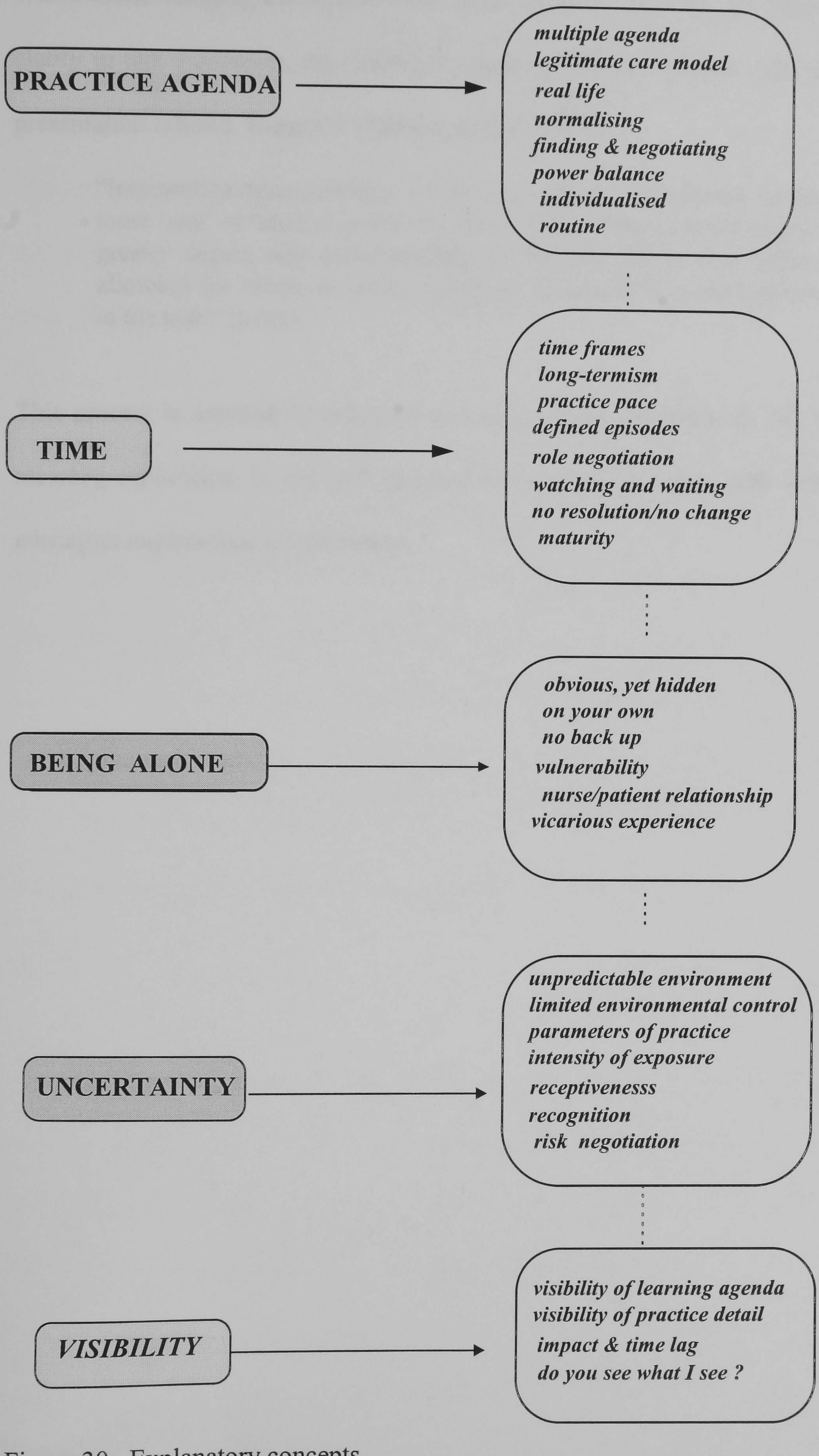


Figure 30 Explanatory concepts

While acknowledging the inter-related nature of these concepts, for purposes of clarity in this discussion, the chapter is presented in five sections. The style of presentation follows Benner's (1994b) guidelines that:

> "Interpretive commentaries or theories are not considered to be more 'real' or 'true' than the text itself. The interpreter seeks to give greater access and understanding of the text in its own terms, allowing the reader to notice meanings and qualitative distinctions in the text." (p101)

This process is assisted by reference to a range of related literature that facilitates meaning explication. In line with the dual focus of this research, both practice and education implications are discussed.

PRACTICE AGENDA

Introduction

This concept has a number of dimensions and it has been present in all phases of the research. The practice agenda is described as open, flexible, negotiated and may be multiple. Practice is rooted in 'real life', the patients home situation, where the patients have as much, if not more power, in the relationship than the professional. Real life is not neat, and consequently the CHNs are exposed to life details that can be difficult to categorise, often leading to normalising processes and debates about where the parameters of the nurses role lie. This is interpreted as an example of what Schon (1987) describes as the 'indeterminate zones' of practice. In relation to this, Schon quotes Pownes who suggests that:

> "we need to teach students how to make judgements under conditions of uncertainty, but this is what we don't know how to teach". (Schon1987:11)

A useful starting point must be developing the explicitness of these indeterminate issues.

Fulton's (1996) exploration of the prevalence of biopsychosocial approaches to nursing practice and Forster and Stevensons' (1996) comparison of the biopsychosocial model and holism, provide some guidance on the journey to understanding the practice agenda of community nursing.

The **practice agenda concept** has 8 dimensions :

1. **Multiple agenda**
2. **Legitimate care models for practice**
3. **Real life agenda**
4. **Normalising**
5. **Finding and negotiating the agenda**
6. **Nurse patient power balance**
7. **Individualised care**
8. **Routine**

1. Multiple agendas

CHNs and students reported a wide ranging practice agenda. Although a specialist practitioner, the CHN is a generalist, caring for a wide variety of patients. This was an aspect of practice which particularly impressed students. A typical focus group comment was:

> "My mentor cared for so many different types of patient, diabetic, terminal...." [stfg1]

Typically students categorised practice according to medical diagnosis, a type of discourse presumably developed during their hospital placements where wards are medical condition specific, i.e. surgical, cardiology, orthopaedic. However, they appreciated that this was challenged in the community. As detailed in the student focus group theme tree '*practice agenda'* (Figure 16), students identify

'individuality' as a governing concept in community nursing practice. They refer to personalised care where you care for " the person and not just the disease".

An issue for CHNs, which was not particularly well recognised by students, was the multiple systems of care with which they were engaged. There is the individual alone, the individual in a family setting, the family needs in their own right and the needs of carers in relation to the individual. This finding is in accordance with Cowley's (1993b) work where she identified that Project 2000 students see the family in relation to the patient but not as an independent focus of care.

The complex and multiple agendas faced in practice are very important issues to note, particularly in the current world where 'value for money' and 'skill mix' are key issues and there is a tendency to reduce practice to the task components. One of the determining characteristics of practising in the community context is that the practitioner has to be able to adapt to diverse patient needs, care conditions and pace of care. Focusing on isolated tasks would miss this aspect of practice completely. A student hinted at these issues during one of the focus group discussions:

> "What struck me was that when you work in the community you need to be very adaptable - you are often faced with different types of patients - it's not that you have to know many new things, but be able to chop and change." [stfg2]

There is also diversity in the caring environment, with students identifying care in hospital as 'standard' and where the environment can be 'taken for granted', compared to the community where the care environment is variable and demands

that the nurse has to repeatedly adjust to different situations. These issues are presented in the 'environment of care' theme trees reproduced in Figures 17 and 18.

It would appear that this research is able to endorse Cowley's (1993a) comments in relation to the government generated 'Value for Money Unit' which :

> "seems to place unwarranted faith in the simplicity of nursing practice. This seems to have led them to consider only single aspects, whereas a multiplicity of factors need consideration." (p166)

When the multiple agenda is complicated further by an uncertain care environment, the complexity is intensified. The context of practice as well as the components of practice are both important, but the impact of context does not appear to have been afforded equal priority in debates about nursing practice and education.

2. Legitimate care models

Legitimising the model of care was an issue for both CHNs and students. Although impressed with the diversity of nursing knowledge demonstrated, the majority of students appeared to struggle with identifying and at times legitimating the care model directing practice. Indeed students debated whether the CHNs were sometimes straying from nursing. They tended to legitimate nursing practice in relation to a medical diagnosis. Hallett's (1995b) study of Project 2000 students during their community placements identified a similar scenario, despite a curriculum that specifically avoided medical diagnosis as a focus of study. The narrative template presented in Figure 28 demonstrates one student's debate of the legitimate

nature of practice. The student initially identifies the content of the visit as focusing on a social rather than nursing assessment. This appears to cause some conflict in relation to the meaning nursing has for him/her. However, as the visit progressed, the distinction between the two issues was considerably narrowed and the student came to the decision that this was legitimate nursing care. Such challenges to the students' developing definition of nursing and the boundaries of nursing practice may not be met to the same extent in other contexts of care.

Reference was made in Chapter 2 to Gould and Harris's (1996) suggestion that social work and teacher education effectiveness may be enhanced if student's' initial frame of reference was more clearly articulated. The issues raised from the discussion of Figure 28 endorse my earlier suggestion that it is not just initial, but developing frames of reference which need to be addressed.

Fulton (1996) reviews a number of hospital nursing environments identifying that the physical care domain takes precedence over a psychosocial approach. In his research nurses preferred to be in a situation where needs were clearly categorised as being sited in the physical domain. Fulton reports to have observed a type of caring which does not recognise:

> "...the lived experiences of the client or patient" (p36)

I would suggest that the community as a context of practice challenges the adoption of this approach and may indeed direct a different form of caring to occur in which lived experience is acknowledged. This has several consequences.

The recognition of social as well as bio-medical model of care widens the potential scope of practice. One CHN made this comparison to what she perceived to be role clarity experienced by hospital based staff:

> "I've heard hospital staff say to family members when they are enquiring about a relative, 'we're treating the so and so, we're not dealing with such and such' and people accept it - but it's not real is it, that's not how people experience illness or how they need care, maybe that sums us up - we deal with people not problems." [chn 3]

However, dealing with 'people not problems' can generate a complex practice agenda. The observed visit detailed in the last chapter in Figures 22 and 23 provides an example of the CHN struggling to determine the legitimate model she should use to frame her practice. For example, referring to concerns about visitors to an elderly patient's home she says:

> "I sometimes feel like checking to see who they are and that she does actually know them and want them there, but then I think - really has this anything to do with me - I don't really know..." [chn1]

Forster and Stevenson (1996) describe nursing assessment as comprising of

> "finding problems and devising effective strategies to solve them." (p137)

Attempting to utilise this framework may be a source of conflict for practitioners in the community as is demonstrated in the clinical situation quoted above. Both student and CHN examples suggest that using a predominantly bio-medical model to make sense of community nursing would appear to be problematic. This is demonstrated in an extract from a practice narrative discussion generated in response to a narrative detailing a patient's care needs which had not been appropriately

acknowledged before discharge from hospital to the community.

> "The other one is hips - because there aren't any beds for bruised hips but a bruised hip can be so painful, people have to come home - they only have beds for broken hips" [chn9]

> "..are you saying that hospital care is driven by medical diagnosis ..?" [researcher]

> "...we aren't talking about conditions, we talk about activities of daily living, that's what we are about, helping people to live and the activities they need to be able to do or we do for them." [chn9]

> "I don't know if I dare say this, but I think community nursing is one of the purest forms of nursing - because you often aren't involved with medicine - it's very much nurse led." [chn4]

The CHNs recognised the students struggle with the care model because they reported having experienced something similar themselves. A number of CHNs reported that when they first began nursing in the community they initially felt they needed the 'permission' of the post-registration education programme to feel comfortable with broadening their practice from their hospital, bio-medical focused care agenda. One CHN described it as:

> "...all the psychological and sociological issues - the things you don't look at in hospital - I also needed to learn that it was right to be interested in all those things, **they are nursing.**" [chn5]

Pearson (1996) recounts her own experience of moving through models of health in her work as a health visitor. When reflecting on her practice over time she is able to identify and to analyse her experiences differently as she gradually worked more closely to a social model of health.

The adequacy of the practitioners' 'heuristic device' is very important. Ashworth and Longmate (1993) use this term to refer to the various models and theories nurses may draw on to engage them into different aspects of a situation:

> "The more dimensions of the situation and surrounding circumstances she can bring into consideration the more understanding and the greater the power of conceiving she has." (p325)

In the introduction to this thesis, reference was made to the recent drive to recruit educationalists with a clinical background in community nursing in order to respond to the changing pre-registration programme. Their role, and the role of any other educationalist with specialist knowledge and experience should be to use their experiential knowledge to facilitate heuristic device development. This action would be in keeping with a post-technocratic model of professional education rather than the technical-rationality approach of specialists being used to apply 'pure' theory.

3. Real life agenda

The CHNs reported a marked distinction between the practice agenda of the community context as opposed to the hospital context. They perceive that the practice agenda in hospital is predetermined, not really negotiable and relatively closed. They contrast this with community where they see the practice agenda as being very flexible and responsive to a wide range of patient needs and the patients general life agenda. The distinguishing feature causing this difference is

the 'level of realism' in the environment of care. CHNs describe the hospital situation as basically false:

> "...it's hard to distinguish between patients when they are all sitting in bed wearing pyjamas. It's when you see them in their own home, when you **really** see them." [chn3]

> "We see people as they really are." [chn 19]

The CHNs were describing a situation where life was in suspension when in hospital, but in the community their practice had to accommodate the patient's life-style and life demands. Comparing the hospital and the community during a practice narrative discussion group one CHN summarised the difference as:

> "There's reality and life in suspension - hospital." [chn 6]

The descriptions given here appear to have much in common with Forster and Stevensons' (1996) definition of holism:

> "...an holistic definition of a person is more than the sum of the parts of the biopsychosocial model. Holism refers to *personhood* as the totality of a person's being embedded in his or her social world." (p136)

One of the consequences of this 'real' situation is that the assessment can be more detailed and the CHN can be exposed to diverse information that may be shrouded from professionals in the hospital setting. This information can be difficult to categorise and utilise appropriately. For example, in a hospital situation a patient may report that 'yes I have a neighbour who helps me out at home'. Rarely would they say 'My neighbour, who by the way is an alcoholic and may use my tranquilliser prescription helps me out at home'. This example was

encountered during the observation phase of the research and is detailed in Figure 22. However, the CHN is exposed to these details that lead on to the problem of 'what is my business' and where should the practice agenda boundaries be drawn.

In the community context, 'real life' is not filtered out of the practice agenda as it might be in the hospital setting. 'Real life' becomes part of the care agenda, although where it should most appropriately fit is not always clear and a source of uncertainty for CHNs. In her discussion of her work as a health visitor in the Riverside Child Health Project, Pearson (1996) recounts a role that changed over time:

> "...my role changed from being a professional 'expert' to being a relatively powerless participant in struggling with the dilemmas of daily life. In the areas (essentially in health care) where the project had power we addressed change, but we did little to alter attitudes of DSS officials, or to deal with glue sniffers and stray dogs." (p27)

Perhaps this is what distinguishes the community as a context of practice, to differing degrees depending on the focus of the role, that the practitioner must contend with more than 'essential' health care. Practitioners are faced with problems and issues for which they do not have 'professional' answers and so have to learn to tolerate a level of professional 'powerlessness'. It would appear however, that this issue of 'powerlessness' is not well addressed in the education curriculum. I would suggest that this is not a surprising situation for a number of reasons. Despite this being an important feature of practice in the community context, admitting professional powerlessness may increase levels of vulnerability for a branch of nursing undergoing a skill-mix review. Even if this aspect of

practice was acknowledged coping with professional powerlessness would be a complex issue to teach or learn.

4. Normalising

People in 'real' life do not conform to a set of standards. Therefore the environment of care can be very variable. This leads CHNs in to 'normalising' or accepting situations. For example during the observation phase one CHN commented:

> "...people live how they want, not how we want, that last lady, I wouldn't like to live in such cramped, depressing, littered surroundings, but for her it's not an issue, I can't and shouldn't make it one, I have to go in and accept." [chn2]

This was reinforced in one of the narrative discussions:

> "We go into palaces and pig stys and anything in between. Some people live in a pig sty and have no problem with it, others live in a pig sty and want something done about it ... [chn6]

Some students were challenged by the 'normalising' practised by CHNs. They often felt the nurse should intervene in some situations:

> "I don't think people should be allowed to live like that - I think the CHN should have insisted that they tidy the place up - I mean they can't really want to live like that." [stfg2]

> "I noticed that they [CHNs] rarely challenged people about things they just seem to tolerate any situation and sort of ignore it - she sometimes mentioned it to me before or after the visit then seems to just ignore it when we were with the patient." [stfg2]

During the focus group discussions students raised the issue of 'standardisation' suggesting that in hospital:

> "in hospital you can take it (environment of care) for granted - its the same for every patient." [stfg3]

These comments suggest that the need to normalise is not met in the hospital situation and may be one of the defining characteristics of practising in the community context. The CHNs act of normalising was often an area of conflict for the students as highlighted in the earlier quote. Students often seem to feel that CHNs were too ready to normalise, whereas CHNs considered that students were often too eager to impose their structure on patients:

> "Students so often seem to have set views on how people should live and they want to impose their values on patients." [chnfg3]

> "Yes I agree, they really seem to find it hard to accept that its not our world its the patients world, we are about helping them to live their life not about telling them how to live it ." [chnfg3]

5. Finding and negotiating the agenda

The practice agenda in the community is seen to be undifferentiated in at least two ways. One practice narrative presented in Figure 28 describes a rather non-specific referral. The CHN embarks on the visit and has to identify a focus as she progresses. It therefore appears that one of the defining characteristics of nursing in the community context is searching for and defining needs. This may be a characteristic in common with general medical practice.

Another CHN in a practice narrative discussion reports a related issue:

> Occasionally you get something thrown at you from the blue - weekends are the worst - you get a name and address and it says dressing and visit on Saturday - sometimes it doesn't even say where the dressing is, so you are knocking on the door not knowing if you are about to dress a wart on the nose or a boil on the bum..." [chn4]

In the theme tree 'decision making' (appendix 8) students referred to CHNs having to become engaged in decisions that were at a 'pre-hospital layer', suggesting that the focus of care is already clarified in most hospital situations. Accident and emergency may be an exception to this general rule, although most patients still present with an identified and immediate need.

The hospital agenda is perceived to be relatively predetermined, focused and closed. The patient is in a hospital ward with a specialism signpost above the door. The patient's and the professional's attention is focused on this issue. The patient is also captive and has a restricted agenda. This perception is endorsed by Fretwell (1980) who suggests that the disease or operation label available in acute wards provides a paradigm for care.

The community context appeared to offer patients more opportunity to influence the practice agenda. One situation reported by a number of CHNs was that of, in their opinion, patients purposefully not complying in order to perpetuate the CHN involvement. This quotation is from an observation phase transcript:

> "...people use you for things other than their illness, that last lady is not complying with treatment, she says she is but I know she isn't or the ulcer would be healed. I know she's lonely, her companion died last year so she uses me as a substitute, if she finds another companion the ulcer will heal, I'll do nothing different, but she will allow it to heal because she won't need me anymore." [chn10]

Other examples were given of the agenda containing explicit i.e. wound care and

implicit aspects i.e. counteracting loneliness. Another CHN said:

> "You come across lonely people in hospital, sure, but you are never the treatment !" [chn6]

The practice agenda in the community was seen to demand high levels of flexibility and negotiation. Contrast the hospital scenario with this visit by a CHN and student to an elderly lady with the aim of changing a leg dressing described in a CHN narrative recording:

> "When we arrived today she was full of woe, curtains closed. We'd gone to change the dressing but ended up having to move the fridge from the kitchen to the living room, then move the tables around. This was what she wanted. I'll go back tomorrow to do the dressing and she will probably co-operate then, today it just was not the most important thing for her." [chn7]

This has similarities with a comment from a student during one of the focus groups.

Although made in relation to communication the essence is the same:

> "...you can't escape from what the patient wants to talk about." [stfg2]

The health care agenda in the community appears to be negotiated alongside the general 'life agenda' with which it competes or perhaps more accurately, which it fits into.

The skill of the community nurse and therefore an important issue for the curriculum, lies in being able to identify a legitimate and appropriate agenda. The ability is reliant on developing an appropriate mind set and models of care to direct practice. In a similar vein, Vistainer (1986) claims:

> "Theoretical maps attain their usefulness by paring down the limitless environment to relevant aspects. All other information becomes background, filler 'noise'." (p36)

The complexity of the signal:noise ratio met in practice and the appropriate theoretical map to appropriately interpret it is an important issue to address.

A key issue for CHNs is one of nurse-patient negotiation. The care agenda and the specific role of the CHN are reported to be repeatedly negotiated. This scenario presents another perspective to Schon's (1987) concept of 'reflection-in-action'. The reflection here being focused on role definition, as well as process of practice.

An example of defining role parameters is presented in the narrative template presented in Figure 26. During the research, several examples were given of patients attempting to involve the CHN in what the CHNs determined inappropriate care issues and to use him/her as an all round /one stop resource to sort out problems life threw up. Patients tried to involve the CHNs in such things as disputes with their landlord and family disharmony. Part of the CHN skill appeared to be being able to function within these apparently rather blurred boundaries and redefine the role as situations arose. There did not appear to be a 'blue-print' for practice, i.e. the same issue may be seen as appropriate or inappropriate in different situations and care histories.

This contrasts sharply with the situation Fulton (1996) met in his research based on hospital nursing. He reports a situation where nurses deliberately set boundaries to their roles, limit their relationship involvement with patients by prioritising the physical domain of care and placing the responsibility for any unmet needs with other personnel.

5. Nurse / patient power balance

The nurse /patient relationship in the community context generates some tensions for both CHN and students. It would appear that what De la Cuesta (1983) refers to as the 'micro-politics' of nurse/patient encounters may be rather different in the community than the hospital setting. Recent changes in health care policy have resulted in a strengthening of the patient's role in the health care partnership. Although all health care professionals will be responding to this change, it would appear that the context of community may mean that community nurses may already be functioning somewhere near the desired manner and may therefore offer students opportunities not usually afforded in the hospital setting.

One CHN reported caring for a lady who always slept in an armchair and not a bed. This did little to assist a leg circulation problem. However, the CHN conceded that this was the patient's choice. Allowing patients to have this choice is a consequence of the environment of care, the patient's home. Forster and Stevenson (1996) suggest that one of the consequences of adopting a holistic approach to care is that there is a shift in the power base of the nurse-patient relationship. They draw on Scaife's (1993) concept of 'heterarchy' in which:

> "...different participants in an encounter shift their positions over time. The position taken depends on the particular activity engaged in, or topics under discussion. No single person permanently occupies the uppermost position." (p144)

Several references were made by students and CHNs to power balance in the nurse/patient relationship. Hospital is seen to be the professionals 'home ground',

they can therefore direct the situation and the patient generally adopts the 'patient role' and complies. In the community, not only must the CHN adapt to and accept a wide range of living styles, s/he must be prepared to function in a much more equal nurse/patient relationship. In the student focus groups comments such as "the patient's more in charge" was very common. Similarly this comment was typical of the CHNs:

> "you can't pull rank over the patient in their own home." [chnfg4]

Negotiation in the nurse/patient relationship was also noted by McIntosh (1981) in a discussion on communicating with patients in their own home. She reports that the community nurses in her study :

> "...had to learn how to be enough of the 'guest' to enable patients and relatives to maintain the feeling that they were still master or mistress of their own homes...." (p103)

This involved moving along a 'passive - assertive' role continuum. Negotiating the appropriate balance of power was not always easy or even achievable. Some CHNs reported that with some patients they felt that the relationship was not balanced and that the patient was very much 'in charge'. This is demonstrated in the comments made by a CHN during the observation phase of the research:

> "that lady we have just visited, she has her catheter bag hooked on to her zimmer frame so that the urine flow has to go against the force of gravity, I've told her why she should not do it etc., but she still does, even when I'm there, it's complete defiance, people don't defy you in hospital [chn2]

A different facet on this theme was raised in the focus groups. Students were struck

at the loss of power, or at least assumed power, they experienced in community:

> "What struck me is that people don't listen to you, in hospital you assume patients are listening to you, but you rarely know if they're not." [stfg4]

> "Yes, I know what you mean, in hospital you advise someone and they nod, here they don't lie to you, they tell you straight." [stfg4]

These comments raise a number of issues in relation to compliance. Firstly, CHNs do not expect total compliance. Some students accept this mode of practice:

> "you do what you know the patient will comply with, not what you think you should." [stfg3]

For other students this caused some conflict as they interpreted the CHN resistance to expect higher levels of compliance as 'backing off' from a conflict or challenging situation. This appears to be a different value system from the students usual hospital environment of care. Playe and Keeley (1998) suggest that compliance is the expected norm:

> "non-compliant behaviour is seen as problematic, because it contravenes professional beliefs, norms and expectations regarding the 'proper' roles of patients and professionals." (p304)

Community practice therefore appears to involve a re-negotiation of professional and patient behaviours. Certainly in community the declared aim is partnership, although levels of frustration do occur as demonstrated in the above quote.

In relation to health care in general, May (1995) suggests that the development of a reciprocal relationship between nurse and patient is a sign of the shift to a new pattern of care. Similarly, Armstrong (1983) refers to a 'reconstitution of patient-

hood'. The passive recipient of care is being replaced with a holistic, subjectively experiencing individual. It may be that community nurses are already practising what Parse (1987) refers to as 'new nursing', where the nurse takes a supportive rather than an authoritarian role.

This concept of 'new nursing' may have relevance to the student imagergy of practice (Gould and Harris 1996) discussed in Chapter 2. Potential nursing students may benefit from reviewing their image of nursing both in terms of the nurse patient relationship and the contexts in which practice occurs.

7. Individualised care

Contrary to what is perceived as standard agenda in hospital, care in the community is seen to be individualised. Reference to theme trees *'practice agenda'* in Figures 15 and 16 provides other examples. Students perceive hospital to provide decontextualised care. The example given by a student related to education after myocardial infarction:

> "...in hospital you address a specific issue, the MI, they try to make it relevant, but you don't know the persons life, not really. I'm not saying community do it better, but they have different information to work with." [stfg2]

Recognising individual needs rather than standard 'condition' packages of care was something CHNs felt students needed to learn. After completing the third visit to elderly ladies to dress leg ulcers during an observation session, the CHN was posed

this question:

> "How do you think the 'average' student would describe this mornings work? [researcher]

> "What would students be saying about today's practice, the ones who haven't grasped community would be thinking they were just seeing more of the same - the good ones would see that we might have dressed three leg ulcers, but three very different people, three different sets of issues and its that, not the dressing technique, they need to concentrate on." [chn10]

This quote appears to provide a good example of the combination of types of knowledge required for practice. In her discussion on models of professional education Bines (1992) makes reference to a similar combination:

> "The knowledge and techniques of technical rationality, that is science and research, are thus bounded and mediated by the arts of problem-framing, implementation and improvisation." (p16)

8. Routine

Following on from the CHN quote above it is possible that some students do take a task orientation perspective. During the student focus group interviews, 'routineness' was a strong theme. Students appeared to categorise a lot of practice as 'routine'. This appeared to be one factor contributing to the dissonance on appreciation of role between CHN and student. A typical comment was:

> "I don't see why they deserve a G grade for doing what a D in hospital does." [stfg1]

The context differential between hospital and community appears to be invisible or insignificant to this student whose comparison argument rests solely on tasks performed.

CHNs conceded that students could deal with the content of many routine visits. However, they stressed that the CHN skill lay in being able to deal with a non-routine visit if this emerged:

> "A routine visit may turn out not to be routine - students couldn't cope with that." [chnfgl]
>
> "...community is about the unexpected - things you can't plan for." [chnfg2]

These comments are very similar to Cowley's (1995) claim that:

> "In health visiting, a routine visit is one that has passed." (p276)

Some of these issues are developed in more detail in the section on risk and uncertainty and it is therefore unnecessary to duplicate them here. However, what must be highlighted in relation to this discussion is that CHNs perceive that there is a actual or potential layer to the practice agenda which students may not perceive. They refer to students not seeing 'all the layers of practice' and particularly not noting the 'peripheral issues'. Again, these issues are only superficially highlighted here and discussed in detail in the section on visibility of the practice agenda and the implications for student learning.

Summary : practice agenda

The community context has been shown to influence the practice agenda in a variety of ways. Perhaps the most significant is the fact that the nurse, indeed potentially any practitioner in this context, is exposed to a great deal of information usually 'filtered out' in the hospital setting i.e. real life issues.

Community nurses are seen to practise to at least a biopsychosocial model or possibly a holistic 'personhood' approach to care. As a consequence some issues are revealed and regarded as significant that would not be seen in a predominately bio-medical approach to care - the practitioners would not be seeking the information and the patients or clients would not be invited to display the information.

Role parameters and the practice agenda are therefore flexible and negotiated which can lead to issues of uncertainty. Managing these situations appears to be an under identified skill.

TIME

Introduction

Different dimensions of 'time' were referred to throughout the research. They raise a different type of issue to those met when discussing the concept of practice agenda. In common with the practice agenda concept, the time concept includes issues of which students need to be made more aware. What is different about this concept is that students may not only be less aware of some of the issues, but generally do not actually experience the issues identified by the CHNs. This dimension to the 'time' concept was therefore influential in the development of the 'visibility' concept which is discussed later in this chapter

The concept of time is very influential in the CHNs understanding of nursing in the community context. They are very aware of the long term potential of their caring relationship with their patients. This means that many care situations have a past and a future. In the focus groups CHNs referred to perceiving that students did not appreciate that patients can 'be yours forever'. In the observation phase I met with the following comments from CHNs :

> "I've been visiting this lady for a long time, we go way back" [chn3]

> "This is a new visit and it isn't, I already have a relationship with this family from previous contacts, so it's not really a 'new' visit." [chn15]

The educational implications may be that some difficulties are created for students as a consequence of their short term membership of a longer term relationship.

The episodic nature of the patient nurse encounters, together with the environment of the patient's home means that the content of the visit has to be comprehensive and has to have an introduction and a conclusion. However, as many care situations are continuing there is a changing and negotiated agenda over time.

The **time** concept has 8 dimensions:

1. **Time frames**
2. **Long-termism**
3. **Practice pace**
4. **Defined episodes**
5. **Role negotiation**
6. **Watching and waiting**
7. **No resolution/no change**
8. **Maturity**

1. Time frames

A long term focus appears to be important to make full sense of the care agenda. This is another facet of the 'real life' issue. CHNs refer to siting the illness or illness episode in the 'real life' of the patient. During the observation phase, a visit was made to a middle aged man suffering with Parkinsons disease. The visit revolved around daily bathing, toileting, feeding and medication activities. When questioned about what the CHN would expect a student to learn from that visit and the other daily visits made to this patient, she answered:

> "It's not so much learning about the illness, Parkinsons, but about **living** with it, how it affects him, his wife .... In hospital you do focus

> on the illness, not living with the illness, you don't see people living, you see a patient." [chn2]

These different time frames must have an impact on student's ability to develop a detailed appreciation of the role and aims of practice. Student placements of a few weeks suggest a short term focus that may work well in a hospital environment where the average patient stay is 4-5 days. Although in relation to the work of General Practitioners, Pritchard's (1992) discussion of differing perspectives on care trajectories is useful here. In comparing GP and patient perspectives he suggests that:

> "The interaction could be likened to a moving train. The patient (in the train) observes an unfolding landscape from starting point to destination. The GP (on the platform) sees a series of windows flashing by, and has to try to put together a coherent view of what is going on behind the windows." (p79)

The descriptions of the lived experience of practice given by CHNs and students appear to suggest that, to use Pritchard's analogy, the CHN gets on the train, but in common with the GP, the students remains on the platform.

Of course, 'community' is not alone in having a long term focus, other hospital specialisms such as elderly care, rehabilitation care, also have this quality, although the patient is then also often 'divorced' from the 'real life' context. What may be an additional complicating factor for learning in the community is that there is not one time focus but several. The care process can have a wide time scale continuum, from one short visit, to daily visits continuing over years.

Long term involvement with a patient may also result in multiple care agendas for example, with a more immediate agenda superimposed on a long term one. The practice narrative detailed in Figure 26 demonstrates this issue and the difference in student and CHN perceptions of it. The patient has an acute skin care need superimposed on a long term, chronic arthritis problem. Although both student and CHN identify the tasks involved, they differ in their appreciation of time-scale. The student appears to have an immediate perspective, whereas the CHN is setting the encounter into a wider time frame. The time awareness appears to be an important factor on the student taking a surface interpretation of events compared to the CHN who sees an underlying purpose and relationship maintenance/investment potential in the activity. Perhaps the fact that the student will not benefit from or experience the fruits of this relationship maintenance activity has some impact on his/her receptiveness to this aspect of the visit.

2. Long-termism

CHNs identified 'long-termism' as something students found difficult to appreciate, but an important element of community practice. By this they are referring to the potential to have repeated encounters/caring relationships with patients over time. Visits or patient contacts were therefore not seen in isolation but as part of a potential continuum:

> "..it's not just this visit, it's what you leave behind you for the next time - if something happens again - it's the impression you leave in that house..." [chn8]

> "What students don't seem to realise, that it's potentially your patient for ever, - that sounds a bit dramatic, but I mean next time they need a nurse - it's you - it doesn't matter whether it's because they become diabetic, have their appendix out, have an MI or become demented or

> their husband, wife or mother has a problem - it's always going to be you, whereas in hospital next time - if it's a different thing it would be a different nurse, even if it was the same thing and the same ward, there's a number of nurses on the ward." [chn3]

CHNs are therefore aware of the potential future in their relationships with patients. It is difficult to identify many hospital environments with this same potential. Some areas e.g. renal dialysis units may have a long term relationship with patients, but it is one condition/specialism focused. It would appear that this is a characteristic which community nurses share most closely with general medical practitioners, rather than other nursing colleagues.

The CHN and the patient therefore have a past and a future. The CHN can draw on previous encounters to make comparative assessments as demonstrated in the narrative template presented in Figure 28. CHNs frequently know the patients personal history, how long they have lived in a certain place, their family's past health/illness history, how they have coped with challenges in the past, etc. In relation to General Practitioner work Pritchard (1992) identifies a concept of 'biographical time'. Assessments and interventions are therefore cumulative which raises potential educational problems arising from the snap-shot view of practice experienced by students.

The time frame of practice therefore impacts on decision making behaviour. Although focusing on property development, Byrne's (1996) discussion on types of decisions is useful here. He identifies two kinds of decisions: single or terminal decisions and multi-stage or 'sequential' decisions. In the latter, decisions are made

by revisiting the situation and it is this type of decision which appear to be most difficult for students to experience.

CHNs identified the nurse/patient relationship as a problematic education issue. For example one CHN said:

> "The relationship thing is difficult for them to learn. I might go into what appears to be a new visit, but I've often had contact with the family before, that person, the grandmother .... it's not a brand new relationship". [chn1]

This is another example of past and future. These scenarios may present particular learning difficulties for students as they may experience an element of exclusion from an ongoing relationship. This is probably a rare occurrence in the hospital setting. It also presents a problem for students taking a lead role in the care giving. They could be seen as a temporary intruder, having had no part of the past and a very short term future.

3. Practice pace

One comparison that CHNs frequently made between their practice and that experienced in the hospital environment was the anticipated pace of change.

Generated from a discussion during an observation interview about some students categorising aspects of community practice as routine, one CHN explained this referring to the concept of time.

> "I can see how a young student could see community as routine, it's the pace and the hours they are talking about - if it finishes at five o'clock everyday - I know there is evening and night service, but you know what I mean, then it can't be that important can it, that's the way they think." [chn 12]

Another comparative hospital /community comment related to the immediacy of impact of practice:

> ... they [students] see intensive care or casualty as the real nursing- it's life and death and if you don't get it right first time you don't get another chance -the impact is immediate, that element of time scale is not so important here - I mean we still need to get it right, but its not often such an immediate issue " [chn10]

In contrast:

> "we may not be generally making these rapid, life and death decisions, but we do have to make it there and then - in full view of the patient - I mean you can't wander off to the office to think about it in private, you have to come up with the goods there and then." [chnfg3]

Another aspect of 'pace' was identified by students. These comments in a student focus group were given general support from other students :

> "Although mine [mentor] was often in a mad dash between visits, she seemed to give the patients the impression she had time for them." [stfg4]

> "Yes, we'd be dashing about, but as soon as we got to the house we were calm and collected." [stfg4]

Pritchard (1992) identifies that GPs may use a variety of approaches to give patients the message that their time (the GP's) is more valuable than the patient's. In contrast, the students appear to be describing a situation where CHNs are actually sending a message to patients that their time (the CHNs) is no more or less valuable than the patients. This may be another aspect of the equal power balance in the relationship.

The fact that care takes place in the home environment can also impact on the pace of practice. In the course of explaining the impact of 'being a guest in the patients home' one CHN said it often meant that some issues had to be addressed over time:

> "...you might not do some things openly, but take a round about way to it - perhaps students just think we are leaving things, but it isn't that - you can't be as up front as in hospital". [chn5]

She was suggesting that the agenda in hospital care is more immediate, declared and focused, not blurred by other issues and accommodating to 'normal' interaction etiquette.

4. Defined episodes

The environment of care, the patients home, influenced the pace of practice. Levels of etiquette are often referred to by CHNs i.e. they are very aware that they are 'a guest' in the patient's home. The speed at which a nurse in a hospital ward can walk up to a patient, draw the curtains round the bed and give an injection contrasts sharply with the CHN who has to knock on the door, accommodate to what the patient was already doing, set the scene to an intervention taking place, perhaps move around the house to the patient's bedroom to achieve privacy, carry out the nursing action, return to the main living area of the house and then 'conclude' the visit to someone's home. The interventions cannot just take place without an introduction and conclusion. The hospital ward provides the opportunity to have repeated and continuing contact with a patient. Community is very different with each episode having a defined closure.

The community context, moving from clinic to clinic, house to house, has the effect of dividing practice into explicit units of time. This manifests in a number of ways. Making an impact in a short time scale was one issue:

> "In hospital there's someone there 24 hours a day, at home we may visit once a week - ok the needs are a bit different, but all the same, we have to be sure we get the understanding across - its not like in hospital where every time you pass someone you can say 'get those legs up'- you have to make an impact in one go at home, without the option for repeated reminders." [chn14]

There is no opportunity to double back and check something, the patient/nurse encounter has to be completed in a defined time scale. This demands a comprehensive and planned approach to practice. On a very practical level one CHN commented :

> "If I forget something, it's a 10 mile round trip back to the surgery - you have to be so organised." [chn10]

5. Role negotiation over time

CHNs appeared to have the general impression that they re-negotiate their role over time, partly as a consequence of developing familiarity with their patients, as well as their aim of siting their practice within the patient's life agenda. Again referring to the narrative described in Figure 26, the openness and continuing nature of the involvement with this couple generated a request from them for the CHN to carry out services that she decided were not within her defined role parameters. In common with the general practitioner, the community nurse is a generalist, and the role parameters may not be clearly defined. This is complicated by CHNs responding to a wide variety of patient needs over time and to a variety of patient needs in the one

community. The consequence may therefore be that patients may understandably develop blurred perceptions of where the boundaries lie.

Another consequence of this role negotiation and ill-defined boundaries could be generation of levels of uncertainty and unease for the CHNs. Holden (1990) suggests that one of the pre-requisites of effective role management is:

> "...being very clear what about which problems belong to oneself and which belong to the patient. In the event of failing to satisfactorily establish such boundaries, the physician or nurse tends to feel as if he or she is responsible for everything...." (p231)

The knowledge and skill to deal with this appear to be practice competencies which are currently relatively hidden and consequently neglected as an educational issue.

6. Watching and waiting

CHNs described a number of care scenarios that involved watching and waiting. One example was that of caring for patients who had failing memory and needed the same information repeated to them on a regular basis. One CHN gave the example of an elderly man who was physically quite debilitated after suffering a stroke. He depended significantly on his wife, also elderly, as his main carer to administer daily medication for him. The wife's memory was failing, although it had not yet been legitimised as an illness. The CHN was in the position of carrying a responsibility for reminding the wife about care needs.

CHNs described situations which "just bubble along", but have the potential to change and demand more complex levels of intervention. They give the impression

that there is an undercurrent of low key activity. The image of someone treading water in a calm sea, but which has the potential to develop a strong current that could prove highly dangerous is an apt description. While the CHN is carrying out some regular activity, they are concurrently monitoring. The issue is complicated further by the 'issues' not necessarily being clearly defined 'medical' or 'pathological' issues. For instance, a crisis could be related to a break down in a family situation and not necessarily any change in the health status of the individual. The time scale of CHN involvement with patients can mean that they are exposed to a range of problems not met in other contexts that may have health implications, but are not specifically health related.

CHNs talked of 'biding their time' and waiting until their and the patient's agenda coincided. For example:

> "Sometimes it's about building up a relationship with someone - chipping away and it's as you get to know them - they give more of themselves - they trust you more - but you know that if you trespass too far perhaps they will close the door and perhaps let nobody in." [chn8]

This has similarities to the situation reported by McIntosh (1981) in which a community nurse in her study concerned about the informal carer of a terminally ill patient:

> "...felt that the only acceptable course of action was to wait until the wife showed further signs of strain, and then repeat the offer of more help more insistently. (p104)

In a similar way the CHN in the narrative presented in Figure 28 talks about keeping a foot in the door by offering the services of an auxiliary nurse while she attempted to get the patient to realise that she had other needs. This could be thought of as a

'passport' activity to the ultimate care aim. The overall impression is one in which the patient's agenda takes precedence and the CHN has to feed his or her agenda into the patient's. This type of agenda negotiation may occur in many nursing contexts, but what is particular about this situation is that the CHN may be exposed to assessment details that alert him/her to issues that the patient has not yet acknowledged. In most hospital situations the patient is there because of an agreed agenda. It may be that mental health nursing may have issues in common with community nursing in this respect.

7. No resolution/no change

CHNs voiced a number of frustrations in relation to slow pace of change or even a total halt in the change process. This was largely in relation to being exposed to situations that fell between service boundaries or outwith service boundaries. The care environment, the patient's home makes it difficult to 'walk away' from the situation, giving a sensation of having responsibility for things which are outside of your control. One situation is being faced with a patient who had unfulfilled needs that the CHN had little success in resolving because support services were not available. They then described living with unmet need, and the frustration and dissatisfaction that ensued.

Another source of frustration in relation to pace of change was generated by patients or their carers. Patients and carers often determined the time-scale of change. CHNs commented:

> "You can't force people to do things." [chn2]
>
> "It's their home, they're in charge." [chn4]

These comments were referring to CHNs having identified an agenda, but the pace of operationalisation was determined by the patient.

A related issue was one of allowing care to be determined by what the patient, rather than what the CHN deemed appropriate.

> "I have to be careful not to intrude on her request." [chn ll]

This comment was made in relation to a patient's decision not to address or discuss the deterioration of her illness and consequent increasing dependency. Nurses in other care contexts are no doubt also responsive to their patients' agenda. However, the community context, which does not have the luxury of the 'safety net' afforded by the hospital context can create a greater level of dilemma in deciding whether to force a patient into a certain care agenda. In this particular example, changing dependency needs may not be critical in the hospital setting as carers are always on hand. However in the community setting, insufficient response to increasing levels of dependency could be critical.

8. Maturity

The time concept was also implicated in the development of the CHNs vision of nursing. The impact of age and maturity were frequently referred to suggesting that:

> "The qualities and essences of community nursing are more apparent to the older eye." [chn6]

> "The kinds of situations and the kinds of communication mean that you have to have had some life experience before you do this job. You

just wouldn't cope coming straight from school you need to know life." [chn6]

". . different things attract you at different times of your life - in my 20s, I worked on a renal unit, I often had to stay on late to deal with a crisis, I found that very fulfilling, now I wouldn't - it's not just about slowing down as you get older - it's about seeing nursing differently." [chn10]

CHNs appear to be referring to developing professional insight and practice parameters as well as gathering life experience. These comments suggest that Eisner's (1991) comments in relation to children may also have relevance for professional development:

> "As children mature their sensory systems become increasingly differentiated. As a result, they are able to experience more and more of their environment." (p17)

Summary - time

Time dimensions are important factors shaping CHNs understanding of practice. Students apparently see a condensed version of practice life, the relationship development, maintenance, and manipulation. The intervention time scale may often exceed the duration of student placements which reduces their opportunity to learn directly about the change in needs over time and the impact of ill health on living. Much of the nurse /patient relationship in the community has a past and future, of which the student plays a very temporary part.

BEING ALONE

Introduction

Practising alone was raised as a concept by both students and CHNs. Although 'being alone' was raised in the first phase of the research the impact of the vicarious nature of this in relation to the student experience was only gradually revealed as the study progressed. The obvious, yet hidden nature of this concept was also influential in revealing the concept of visibility of practice in the community context.

The 'being alone' concept has a number of dimensions related to practical support, personal vulnerability, and professional collaboration.

Being alone is referred to with varying degrees of explicitness in other studies focusing on community nursing practice. For example, Kenyon et al (1990) make a number of references:

> "No longer is a colleague nearby to consult" (p34)

> "Nurses new to community health frequently express feelings of isolation." (p34)

> "Independent practice in the acute setting is desirable, in community health nursing it is a must." (p38)

In relation to community nursing practice Mackenzie (1992):

> "Here, nurses practice in a patient-controlled environment where immediate decisions have to be made without recourse to consultation with either nursing or medical colleagues." (p682)

However, despite these references to being alone, I suggest that the full impact of this aspect of practice and the educational ramifications have not been fully

acknowledged or addressed. Although working alone is something community nursing has in common with other professions such as social work, there is a scant literature on this aspect of practice. A review of social work and nursing education literature over the past decade failed to identify any work that focused on the educational preparation for practising alone.

The **being alone** concept has 6 dimensions:

1. **Obvious, yet hidden**
2. **On your own**
3. **No back up**
4. **Vulnerability**
5. **Nurse/patient relationship**
6. **Vicarious experience**

1. Obvious, yet hidden

Although as a hospital ward sister she realised that CHNs worked alone, one CHN had not really appreciated the impact this would have for her before she changed roles. Having someone else in the environment was a taken for granted aspect of hospital practice. Only when it had gone was the nurse aware of it:

> "...in hospital you check so many things, not just drugs, without really knowing it - you don't realise until you come out here and there's no-one to check with how much you actually rely on checking." [chn1]

This comment, made during the observation phase was very instrumental in revealing the vicariousness of students' experience in relation to being alone, i.e. they rarely visit alone and therefore do not experience this aspect of practice. It also raised

the issue of 'visibility', that something so obvious as CHNs working alone had been visible, but not seen. It is useful at this point to refer back to Eisner's (1991:1) comments (discussed in Chapter 2):

> "Seeing, rather than mere looking, requires an enlightened eye..."

2. On your own

This has at least three dimensions; developing a 1:1 relationship with the patient, being isolated in terms of taking responsibility and the lack of physical presence of another person.

Relationships with patients may develop differently to the hospital situation and have different components. The normal day to day conversations which hospital nurses have with their colleagues are had with patients in the community setting. The long term relationship also means that the 'sharing of self' is an element of community nursing, partly the therapeutic use of self and also as a consequence of working in isolation from other colleagues.

Responsibility was rarely shared with colleagues as the majority of practice was carried out alone. Both CHNs and students were aware of this characteristic of practice. These were typical remarks made by students during the focus groups:

> "It would frighten me, being the only person there, having the whole thing on your shoulders, until you experience community you don't realise the difference in responsibility." [stfg3]

> "What got me was that there was no-one there to double check." [stfg4]

'Checking' was a recurrent issue. Two aspects of 'checking' or verifying were identified. One related to checking with a colleague, the other related to opportunities to check out your own decisions. First, checking with a colleague:

> "...it's a different ball game out here - in hospital they worry about getting someone to countersign for two paracetamol - I give out morphine alone here, people give themselves paracetamol all the time - hospital formalises every thing, what is normal and usual activities are made difficult and false." [chn3]

Working alone means that the CHN can rarely confer on decisions. They have to be fairly self sufficient in their knowledge base, at least in the initial stages of dealing with a problem. The 'being alone' element therefore adds an affective element to the process in addition to the knowledge base. Students identify that confidence in your ability is essential to meet the demands of making solo decisions. They identify that there is no-one to confer with but also strongly identify that there is no-one to 'check' with, perhaps an indication of their unreadiness for unsupported practice.

The issue of being alone does not just relate to the lack of opportunity to draw on another person's expertise, it also relates to physical presence. As one CHN said during an observation interview:

> "...there is always someone there in hospital, a second -person comes to your aid - another nurse, another body, not necessarily someone qualified, just another body." [chn2]

3. No back up

One CHN used the phrase 'no back up' in relation to having to persuade or encourage patients without the assistance of colleagues. She particularly referred to

the weight of the hospital consultant's voice which apparently is fairly certain to achieve patient compliance:

> "...the other thing you have in hospital is an awful lot more backup - you have the consultant coming along saying come on this has to be done - so it's a bit more authoritarian. We are very much more in the contract business - this is what I can do for you, but this is the element you have to do." [chnfg2]

It may be therefore that the combination of working alone, episodically [without a constant drip effect], in the client's home ground, has an impact on the style of communication and the perception of impact of communication.

Backup or personal support from colleagues was identified as being available at a distance:

> ... it's a two tier, you are there on your own in the home on the one to one and there's the immediacy of it and then you come out and you've got the support of your colleagues." [chn8]

4. **Vulnerability**

Many CHNs describe hospital as a safe and protected environment whereas there could be a level of danger in the community that had to be faced alone. This example from a narrative discussion raises issues of vulnerability:

> "...for example one visit this morning I could see the student was petrified and we were there together. We went to a house supposedly about a continence problem. The husband opened the door and he was tiny, shifty looking and he whispered, 'she's asleep, don't wake her, she's a terrible temper when she's woken up - so immediately you think oh no, what's going to happen here, he keeps telling us to keep our voice down, we're talking in whispers - 'if you wake her and she finds I've asked you to come she'll go off it, off it, violent temper'- and I could see the student thinking oh my God - then we hear this noise, the bedroom door opened and I thought oh crikey, expecting this axe murderess to come in and in she comes, this lady with a smile on her

> face, but he's standing behind waving his arms mouthing 'keep quiet'- it turned out all right, but it could have turned out to be anything - you never know what's going to happen - I told [student] I always keep myself with an exit..."[chn9]

CHNs felt that the skills to cope with such situations were partly influenced by personal and professional maturity:

> "I always tell students that they really need to get some life experience first - because often you are put in a situation where you're on your own and have to think on your feet - you just have to have that experience to be able to cope." [chn6]

This CHN was not alone in suggesting that the ability was more an issue of osmosis of life events rather than an education event. These issues were developed in relation to the role of the community staff nurse, particularly Dip HE/RN students working in the community immediately on qualification:

> "I don't agree with it, they haven't got the life experience any way - it's all we've been through before we came into the community, all the responsibility... they can cope in hospital, but that's not like here, you have people there, superiors above you - there's always someone there - you're not isolated in somebody's house in a difficult situation when you can't say to anyone do you think this is right." [chnfg4]

5. Nurse/patient dyad relationship

The dyad relationship needs to be explored from two perspectives; the implications for the CHN of working one-to-one with patients, and the implications for the student learning experience.

The CHN's usual relationship with his/her patient is a one-to-one. As one CHN commented:

> "You can really get to know people, there is only the two of you - what I mean is there is just you and them - the patient, the patient and family- you know what I mean. Other people might be

> involved, probably will be involved like the GP but not in the house at the same time. There's something different about the fact that it'll be you at the next visit, or even if it's the only visit - you're not part of a group- you are there on your own. [chn 2]

It must be remembered that the environment of care in which this dyad relationship is developing is the patient's home, providing the attributes for a level of intensity to the relationship. As one student said in the focus groups:

> "The intensity of the relationship struck me, how much they [patients] divulge and open up to you. It seems like you're in their home so you're part of them." [stfg3]

Several CHNs talked of 'giving of themselves' 'sharing some of their personal self,' not just professional self with their patients. They explained that working in someone's home on a one-to-one over a period of time made this virtually unavoidable. Balancing the professional and personal was a conscious effort:

> "Getting the balance right between being cold and over friendly- you're not visiting a friend, but it is someone's home." [chnfg4]

The dyad relationship raises issues for student learning. The student's presence has the potential to markedly change the usual dyad relationship. Firstly, the majority of students do not visit alone, or at least not for a consistent time period. They therefore do not really experience the dyad relationship and the communication that ensues. Whether students appreciate that they are not experiencing this aspect of practice is debatable. Some insight is gained by reflection on students' awareness of 'being alone' which is discussed in the next section.

The second issue is that the content of a dyad as opposed to a triad visit may differ. It may be that patients store up issues for when the nurse is not accompanied by a student. Students may therefore be exposed to a 'filtered' experience.

6. Vicarious experience

Students rarely experience practising alone and it is something that cannot be truly perceived until experienced. Students can imagine it and indeed present a range of perceptions on this aspect of practice. However , on the whole it is only the CHNs who live it.

Some students interpret working alone in terms of freedom from supervision and imposed restrictions:

> "Community nurses have much more autonomy. There's no one looking over your shoulder all the time - they dictate their own day, when to have lunch breaks, some days they finish early, other days they work late - they can just even the time out for themselves - it's very flexible." [stfg2]

Those students who interpret working alone as being a luxury situation of being unsupervised are rather frowned on by CHNs as not having grasped the true essence of working alone. In particular they feel that the students have not understood the complexities of self organisation, caseload management, identifying, interpreting and prioritising needs and time.

Some students are fearful of the responsibility of working alone:

> "They have to be sure of themselves, you can't just turn round and ask someone if you're stuck - you're on your tod - that would frighten me , being the only person there and having the whole thing on my shoulders. [stfg3]

> "It's a very responsible job - a different kind of responsibility to hospital - in hospital there is always someone to turn to ." [stfg3]

The CHNs evaluate the last two types of comment as an indication that these students have understood some of the issues about practising in the community context. One CHN's comments were endorsed by others:

> "Students can't know what it's about - they are always with us - or virtually always - you might select a few carefully selected patients for some to visit on their own - but that's only letting them take part of the responsibility. Some realise it - they're the one's who say they would be concerned about visiting alone - they at least realise there is something to it. The other sort of student worries me - the ones who don't seem to have grasped the responsibility issue - the deciding on your own issue - they don't seem to realise how cocooned they are visiting with us. It just seems to go over their head - they don't grasp it - but there again they don't do it so it's expecting alot of them I suppose". [chn 14]

Summary - being alone

'Being alone' has implications for nurse/patient relationships and communication. It carries a different level of responsibility to that experienced in hospital in view of only one assessor being present and limited opportunities to confer on decisions. Vulnerability may be experienced in a personal safety sense, but also in terms of not having a second opinion on situation assessment and response.

The impact of working alone may be 'hidden' to observers and outsiders and it is difficult to experience this type of working practice vicariously. It may also be hidden to researchers as they do not experience practising nursing alone, or observe it taking place. I would therefore suggest that this was an issue that may have become meaningful because of my status as an insider researcher and the fact that the discussions raised by the respondents triggered experiential understanding for me.

UNCERTAINTY

Introduction

This concept initially appeared in terms of CHNs identifying that students may not be able to cope with the unpredictability of practice in the community. The dissonance with the students' comments on the 'routineness' of practice made it stand out more. These issues were developed and transformed into the concept of uncertainty when linked with the issues of role boundary negotiation, working alone and distribution of control in the nurse/patient relationship.

Discussing their practice CHNs report experiencing different types of uncertainty that include elements of risk. The context of practice is reported to be unpredictable. In particular, the context exposes the practitioner to complex personal and family situations. These issues are exacerbated by the fact that the community nurse generally works alone which reduces the opportunity for collaboration. A similar interpretation of the care environment is reported in relation to the related profession of general practice. William's (1995) has defined general medical practice as:

> "...a branch of medicine characterised by high levels of uncertainty...grey areas exist where it is impossible to formulate an exact definition of the problem which might include not only physical but social, psychological and environmental components." (p294)

Likewise in relation to health visiting, Cowley (1995) suggests that :

> "The management of uncertainty and ambiguity are central to the role." (p276)

The **uncertainty** concept has 7 dimensions:

1. **Unpredictable environment**
2. **Limited environment control**
3. **Parameters of practice**
4. **Intensity of exposure**
5. **Receptiveness**
6. **Recognition**
7. **Risk negotiation**

1. Unpredictable environment

One type of uncertainty CHNs referred to was in terms of not knowing what type of situation they are about to face. To quote one CHN with 18 years experience of community nursing:

> "...you knock on the door and you don't know what's behind - in a sense that's what gets the adrenaline going - I always take a deep breath when I knock on a door for the first time." [chn5]

This stage is prior to being faced with making a decision that may have an uncertain outcome. It is about a state of expectedness about what may happen next, yet with few, if any landmarks. To some extent this may be a familiar feeling for other nurses, for example those practising in Accident and Emergency departments. However, what distinguishes the experience for the community nurse is:

> "You get out of the car, you knock on the door and go in - **alone**, you have an idea what to expect, but you can never be sure." [chn3]

2. Limited environmental control

Uncertainty is also created because CHNs do not have full control of the caring environment. The context of practice is the patient's home. The patient has a greater degree of control of the situation than the hospital based patient. For example, a CHN commented:

> "...you sometimes have to wait for things to happen." [chn1]

This CHN was talking about an elderly client who was living in an unsafe environment. The CHN felt in a state of uncertainty having identified a potential risk to the client, which the client refused to take measures to avoid. The CHN was then waiting to see "if anything [an accident] happened." The nurse reported not being in full control of the decisions. The client had an element of control that was distinct from that possessed by the hospital based patient.

In relation to medical uncertainty, Holden (1990) suggests that it is:

> "...inextricably linked to an ill-defined sense of responsibility which in turn generates guilt and anxiety. Katz argues that one of the major defences standardly employed by physicians (and *ipso facto* - nurses) against anxiety of uncertainty, is to establish authoritarian relationships with patients and colleagues." (p231)

The source of uncertainty is recognised in the community nursing situation, but the solution or coping strategy is contradictory to the nurse / patient power base described by CHNs.

3. Parameters of practice

CHNs appear to work to a diverse definition of health and they are prepared to explore widely to identify health needs. However, this can create dilemmas of where

the boundaries of practice should lie. CHNs reported a number of visits where they entered into a personal debate as to whether they should intervene and respond to needs they *thought* they had identified:

> "I call them support visits, I go in looking for x, y and z, but just say 'how are you today', there's something in with how they respond - you have to decide whether to pry or not." [chn8]

> "You need to be a bit of a detective in this job - chipping away at something to see if there is anything there." [chn7]

Another CHN's comments gave a slightly different perspective on this type of uncertainty:

> "You go in and you know there is something, but there is nothing...you continue to probe...you might be on the wrong lines, you're not 100% sure that you are right - you could be hanging yourself...it's about putting yourself on the line." [chn9]

The context of practice, patients' homes, has the potential to expose the CHNs to intense situations. The impact of context was raised by several CHNs:

> "Things you would never touch on in hospital- you see family life as it happens, warts and all - you might have to deal with it or acknowledge it or try not to see it." [chn4]

This relatively 'unfiltered' environment of care appears to pose new dilemmas, assessment criteria and scenarios for the CHNs. They may therefore be faced with selecting from a wide range of potential responses - conditions for risk and uncertainty to flourish.

5. Receptiveness - to the possibility of risk

The CHN focus groups raised the theme of 'seeing things'. This has direct relevance to the idea of alertness to potential risk. CHNs described themselves as being continually aware of the risk potential. They perceived that students were rather oblivious of this layer of practice. One factor that may explain this discrepancy may be that students are protected by their mentors and therefore do not experience the working alone situation and the responsibility for practice. If students do carry out visits alone, mentors will have carefully vetted the situation before-hand. It would appear therefore that the two groups experience two different forms of reality.

It must also be identified that even if the CHN attempted to share this aspect of his/her world with the learner, it would be difficult to encapsulate what they were uncertain of or trying to predict because they are open to the whole potential of the patient's life agenda.

6. Recognition - of the potential for risk

There appeared to be a discrepancy between students and CHNs in their visions of the nursing world. Some of this discrepancy can presumably be explained by the difference in nursing experience and education between the two groups. However, some of the difference may also be due to different signal searching and recognition between the two groups.

The wide and varied parameters of practice in the community, exacerbated by the intertwining of health and social care, may have the effect of creating a high level of 'background noise' to potentially interfere with signal recognition. CHNs described

carrying out nursing activities while being involved in a state of watchful alertness. In Cowley's (1993) work on skill mix in community nursing she warns that decisions about delegation should not be focused on task or patient category, but the predictability of the situation. The CHNs endorsed this assertion. The essence of this quotation from one CHN was repeated by several others:

> "A routine visit may turn out not to be routine - students couldn't cope with that." [chnfg1]

Another commented:

> "Community is about the unexpected - things you can't plan for" [chnfg1]

Sharing the process of being 'alert' and recognising potential risk would appear to be an important aspect of learning to practise in the community context. However, sharing the details of a task with the learner is the easiest aspect of practice to articulate. Hallett's (1995) study of Project 2000 students in the community identified that students relished the opportunity to develop their technical nursing skills e.g. dressings, catheterisations under the one to one supervision of the mentor and without being in competition with other students for the experience, as was the case on the hospital ward. The consequence of focusing on task details is that this may be the learner's primary consideration. The construction which learners make of community nursing is largely determined by the building blocks of information presented to them by CHNs and the issues they have been alerted to in the classroom setting. By favouring the task oriented and espoused knowledge paths to sharing clinical knowledge some facets of practice may be hidden.

7. Risk negotiation

One factor that may greatly influence the level of uncertainty and risk in the community is the power balance between patient and nurse and control over the care agenda. This issue of control of risk and where the power to do so is located is further developed with reference to Sines (1995). He describes community nursing as providing care within a negotiated client-directed care plan. This may include calculation of risk and endorsement of a course of action chosen primarily by the client. This level of power in risk management was a repeated area of conflict between CHN and student. Students often found it difficult to accept the level/amount of power the CHNs allowed the patient to hold. CHNs repeatedly rationalised their practice decisions by saying:

> "...you have to do what the client wants, you can't force them. Students want to take control, you can't do that in the community." [chn10]

It may be that CHNs work to this agenda but struggle with the risky situations that result. They do talk about not switching off:

> "I'm often not 100% happy when I leave a patient. I know no one else is there for them for the next 24 or 48 hours and I often don't feel comfortable with that." [chn1]

In relation to risk taking in rehabilitative care, Cook and Procter (1998) raise the moral dilemma of beneficence versus autonomy. They refer to Beauchamp and Childress (1994) who suggest that:

> "...moral principles can never totally outrank each other....the principles of beneficence and autonomy need to be balanced, and that the relative priority given to each will depend upon the circumstances of particular cases." (p285)

This appears to closely mirror the source of uncertainty encountered by CHNs and their struggle to balance the two moral principles. Interestingly students appeared to be drawn to favour beneficence, although it is difficult to say if this is a deliberate moral choice or a more manageable option for a learner to deal with.

Another important factor that may contribute to the feelings of uncertainty is that although the CHNs refer to sharing decisions with the patient, they have limited opportunity to share professional responsibility. Therefore on one level the decision is shared, but at another it is carried solely by the CHN.

Summary - uncertainty

Practising in the community context, accommodating the life agenda of the patient exposes CHNs to information and scenarios which creates dilemmas and uncertainty for them. The importance and impact of these issues of predictability and risk are exacerbated as a consequence of practising alone. As students do not generally practise alone, these issues are not particularly visible to them and therefore pose a significant educational challenge.

VISIBILITY

Introduction

The issue of students not seeing all layers of practice was raised by CHNs in the focus group discussions. However the concept of visibility really began to become apparent during the observation phase when issues about not unpacking all the potential learning were discussed. Practice narrative discussions developed the idea that some practice had not been visible to students. Further reflection on the issues linked visibility with the concept of vicarious experience of practice.

It appears that some of the defining characteristics of practising in the community context, in particular, 'working alone', 'risk and uncertainty', 'time scale' are virtually invisible to students and to some extent to the CHNs, posing considerable educational implications.

The **visibility** concept has 4 dimensions:

1. **Visibility of the learning agenda**
2. **Visibility of practice detail**
3. **History and time lag**
4. **Do you see what I see?**

1. Visibility of the learning agenda

During the narrative discussions CHNs were asked for their comments on any differences in the detail presented by the CHN and student narratives. There generally was a difference, with the CHN narratives being more detailed. This was to be expected. However, the CHNs were disappointed at the lack of detail some students gave and that some issues seemed to have passed them by. The CHNs seemed to go through a 'dawning experience', realising how much of their role was not immediately visible to the students:

> "May be that's all that came across to the student..."[chn9]

> "That's a danger, the student can only pick up what she has heard and what the CHN has said - it depends how much depth the CHN has gone into, this one doesn't appear to have gone into much depth." [chn14]

The CHNs did report experiencing difficulty in knowing where to start to unravel their role to reveal to the student:

> I sometimes think I've forgotten the details of the basics, and that's what they need to know, I just do them." [chnfg4]

> "I know what you mean I do sometimes worry about getting down to their level and being sure what their level really is." [chnfg4]

These comments are relevant to Girot's (1993) discussion and specifically the reference to Boyd and Fales (1983) who talk about "bringing into consciousness what is done naturally". In order to teach or mentor in the clinical area, the practitioners must firstly make the detail of their practice visible to themselves. This is not necessarily an easy task and it would be useful to quote Itano (1989) who refers to "...complexity hidden in its familiarity."

The visibility of the student role was also raised. One CHN said:

> "In hospital the student knows very quickly where their place is - they have to search a bit more here." [chn10]

2. Visibility of practice detail

Moore (1986) refers to accessing situated knowledge. The most common route in nursing is through observing the overt tasks or behaviours that constitute nursing practice. However, simply observing is probably insufficient to appreciate the knowledge embedded in practice. This may relate to a general education issue as well as specifically to the learning available in the community context.

Vistainer (1986) suggests students have to decode actions in order to understand what is actually happening. This could be interpreted as having to look beyond actions to fully 'see' nursing practice. It may be true to say 'What you see is what you look for'. If you are looking through a predominantly single vision, medical model lens then you see and value technical, cure related activities. However if you are using bifocals that have a medical and humanistic lens then you would value and be prepared to see different aspects of practice.

When asked during an observation period what a student would be expected to learn from a particular visit, the CHN responded:

> "I'd expect her to pick up on the environment and the atmosphere, the tenseness between husband and wife ... unspoken issues like the relationship in the home." [chn1]

Technical skills or tasks were not even on the agenda here.

According to some CHNs students experience some difficulty in seeing the practice agenda.

> "Some [students] aren't prepared to look very much, hospital has made them lazy and they are used to seeing the obvious, because it is obvious in hospital, it's so much more clear cut." [chn2]

There was a general belief that the care agenda was a much more accessible and obvious issue in the hospital setting. Fretwell's (1980) research on the ward learning environment reported that students perceive a good learning environment to have varied work, specialist and highly technical nursing. In their critical examination of nursing knowledge, Reed and Procter (1993) raise the issue of some nursing work being categorised as natural work and thereby unproblematic. Community nurses are often involved in sharing care with lay carers or even carrying out care because of absence of informal carers. Students categorising practice in this way may therefore see limited learning agenda.

Being able to work alone is a crucial element of community nursing. However, the detail of this working environment was generally hidden from the students. They rarely worked alone and if so with very carefully selected cases. Even so, they never experienced the responsibility level carried by someone actually functioning as a lone community practitioner. As one CHN said:

> You have to experience it to know what it feels like, the responsibility, the decisions are so different." [chnfg4] "

CHNs also reported selecting out aspects of practice so that students saw an abridged version of reality. The rationale was generally to protect patients from turning the

dyad relationship into a triad, either because they had been exposed to too many students already or that the detail of the care would be hindered by a third and temporary party.

The 'behind the scenes' negotiations experienced by CHNs may be difficult to see. In relation to having to accept that patients could manipulate and direct the care agenda much more in the community than in hospital one of the consequent frustrations was:

> "...I know, I have the knowledge, but I can't implement it the way I would like to, largely because she [the patient] doesn't want to know [patient did not want to change lifestyle to accommodate a health problem] and I have to make the best of it. It's easy to know and implement, it's frustrating and challenging to know and not be allowed to." [chn2]

This consequence of the nurse/patient power balance difference in the community may be difficult for students to appreciate if an 'end product' view of practice rather than a 'process' view is taken. The episodic nature of the work may also make it difficult to pursue the detail of different scenarios. For, example during the observation phase these quotes from CHNs are very pertinent. Researcher and CHN were beginning to discuss the complexities of the previous visit when the CHN stopped the car outside the next patients home and said:

> "I'm sorry we can't talk about that any more, we have to get on with the next visit now." [chn3]

Returning to the car after completing a visit the conversation on the process of the visit was cut short:

> "I don't think we should talk any more now, she'll [patient] be watching us out of the window and might get concerned that we have a lot to say about her - let me drive off then we'll pull up round the corner." [chn3]

Time restrictions may play a significant role in students not having the detail of practice highlighted for them:

> "...we might be caring for a person, going in today to do basic nursing care, the living conditions and the family dynamics may be intense but we can't unpick it for the student every time, we are working with it, accommodating to it, monitoring it..." [chn2]

There may be an element in here of reluctance to unpack all practice detail because of the short term nature of the student placement i.e. the student may not be going into that family again, and also another student may be allocated next week and the whole story will have to be recounted again.

The CHNs' views generally contrasted strongly with those of the students who believed that the content of practice was straight forward :

> "I don't think there should be any difference in knowledge for community nursing practice - they need to know about a lot of things - a wide knowledge base, but not necessarily to the level of the hospital nurse specialising in it. Although they are specialists in things like wound care and they do seem to value communication more. [stfg4]

CHNs gave a rather contrasting viewpoint:

> "Well, there's a layer they [students] don't understand, it's hard to say exactly what it is, but if they think they can come straight out they have missed something." [chnfg 4]

There are a number of potential explanations for these conflicting perceptions. There may be suggestions here that there is a closed learning agenda i.e. students looking to learn what they are familiar with, only being tuned into learning the type of issues encountered in the hospital setting, specifically technical tasks. An alternative

explanation is that it is not just about not looking for different types of learning opportunity, but that the learning potential is difficult to see and the students need assistance to sharpen their vision.

3. History and time lag

Visibility may also be affected by the time scale of practice. CHNs often referred to the history attached to nurse/patient relationships. This could mean being a familiar face from casual encounters in the GP surgery over time, having previous involvement with this patient or previous or current involvement with the patients' friends or family. This history has an impact on the nurse/patient relationship that is not easily visible to the observer i.e. the student. As one CHN explained:

> "...the relationship thing is difficult for them to learn. I might go in to what appears to be a new visit, but I've often had contact with the family before, that person, the grandmother, ... it's not a brand new relationship." [chn1]

The time lag between intervention and outcome may be another source of problems. The time scale of the CHN intervention may be months, even years. Students see a 'snap shot' of the whole. The outcome of the intervention may therefore not be visible to the student. Indeed CHNs talk of putting some aspects of care 'on the back burner' until the patient is more prepared to co-operate with them, possibly as a consequence of 'underlying' negotiations. However, during a short placement, the student only sees that the CHN appears to be dropping an issue. In fact they are probably observing the operationalisation of a humanistic approach to nursing which

McKee (1991) defines as:

> "..an approach which treats the human being as unique and unpredictable, which attempts to view him as a whole, where emphasis is on his own perspective of the lived experience." (p172)

I am not making a claim here that only community nurses practice humanistic nursing, but the context and the history of the relationship with patients allows the approach to be demonstrated in a different and perhaps unfamiliar way.

4. Do you see what I see ?

Kelly's (1955) personal construct theory suggests that we should be wary that what is in the practitioner's head is not necessarily automatically translated into the learners head.

One CHN used a visual analogy to distinguish CHNs and students:

> "...a CHN has a wide angled view on the world. Students are like male drivers and CHNs like female drivers. Male drivers have a very tunnel vision approach compared to female drivers who are more likely to take note of the surrounding environment as well as the road infront." [chn2]

This has implications for the repeated accusations made by CHNs that students "don't see all the layers of practice". Student and CHN may have different 'cognitive lens', being driven by different care agendas or models. During a narrative discussion focusing on the narrative presented in Figure 28, one CHN commented:

> "The statement about the cuff size is typical of a student - a typical very practical focus and comment. I know you can use different size cuffs and there's research to suggest some rather than others, but that's a beautiful comment - it fits into a box, that's what they like to do -

> they are in this house where the client is covering herself in talc rather than washing etc. and the student thinks it's important to focus on the cuff, it's a gem." [chn14]

Visibility of role parameters or definition can potentially be problematic for CHNs, students and recipients of care. Both student and CHNs enter into debates about where the boundaries of the nursing role lies. Observing practice provided opportunities to request clarification of why a G grade was carrying out activities such as personal hygiene tasks. The response was that there was also a hidden agenda of monitoring patient coping and pain relief effectiveness. However, what was obvious to the observer was the tasks performed, unless highlighted by the CHN the other issues were indeed hidden.

There are other facets to the role boundary issue. The CHNs experience the uncertainty and dilemma in some situations of 'is this my business', 'should I get involved', 'am I picking up the right cues and interpreting them accurately'. This suggests that the practice agenda and the nursing role is not very obvious and may need to be negotiated. Students appear to experience some conflict in accepting some aspects of the CHN role as nursing. For example some aspects of social assessment as discussed in Figure 28.

Summary - visibility

The care model driving practice may be influential in two ways. Firstly, a more pronounced emphasis on diverse definitions of health may be evident in the community. Secondly, even when the same model is being used in hospital and

community, the community context of practice allows it to be operationalised in a different way. As a consequence the agenda may be both less accessible and less familiar to an observer, particularly a short term observer.

The visibility of the practice agenda for the community nurse may at times be blurred for both the CHN and student. This is partly because there is considerable role negotiation to accommodate varying care environments and multiple and superimposed agendas.

Another complicating factor is the time-scale of the CHN agenda may mean that students only see a snap shot of the full intervention and have difficulty accommodating to the history of the nurse/patient relationship.

Summary : meanings and interpretations

Five overlapping and multi-dimensional concepts of 'practice agenda', 'time', 'being alone', ' uncertainty', and 'visibility' appear to be significant for understanding nursing practice in the community context.

The practice agenda is influenced by information usually 'filtered out' in the hospital setting i.e. 'real life' issues which have to be accommodated. Community practitioners may therefore be exposed to and look for a range of information which may not be met in a hospital setting. Role parameters and the practice agenda must therefore be flexible which can lead to issues of uncertainty.

The concept of time is very influential in the CHNs' understanding of nursing in the community context. There is a long term potential to the caring relationship and many care situations have a present and future. This can create some difficulties for a learner on a short term placement.

Working alone carries a level of responsibility and a type of decision making not experienced in the hospital setting. However this defining dimension of community nursing is usually only experienced vicariously by the learner.

Working within the real life agenda of the patient, together with practising alone, can create dilemmas and uncertainty for nurses practising in the community context. Again this is an aspect of practice about which students may only achieve a limited awareness.

Issues such as role negotiation, particularly over time, vicarious learning experiences suggests that elements of practice may not be clearly visible to the learner.

The interpretation of these concepts is developed further in the next chapter ' Integration and Discussion'.

CHAPTER 7

INTEGRATION & DISCUSSION

Introduction

To quote Darbyshire (1994a) the aim of interpretive phenomenology is to:

> "deepen understanding by uncovering, illuminating and interpreting important themes." (p182)

The discussion in this chapter continues to develop the illumination process culminating in identification of the phenomenon of nursing in the community context. Further discussion then integrates this study into the wider arenas of nursing, education and research. It is important at this point, to clarify the rationale for the discussion. Objectification is not the intent of phenomenology (Schwandt 1994, 1996, Darbyshire 1994a), it aims to develop understanding. Darbyshire (1994a) describes his management of this as :

> "In my interpretive analysis I have sought to construct an account that neither merely reproduced participants' experiences nor trivialised them by superimposing a dominant or authoritative view of what they 'really meant'." (p183)

I am also attempting to achieve this balance within a research framework which combines phenomenology with constructivism and which set out to both enhance the way in which practising nursing in the community context is understood and clarify educational need. The purpose therefore of integrating the understanding developed in this research into wider arenas is to further envision nursing and learning to nurse in the community context. This approach is guided by the notion of an analytic or interpretive continuum. The process is seen to begin with revealing meaning and then exploring the revelations, similar to Allen and Jensons' (1990) distinction between 'textual description' and 'textual disclosure'.

In the introduction to this research I made reference to the work of Kenyon et al (1990) who were eager to redress the assertion that nursing in the community is "... nothing more than a change in practice site". By constructing CHN and student meanings of practice it has been possible to identify a number of defining attributes of nursing in this context. These suggest that practice in the community is different to hospital-based practice on a number of dimensions. Although some of the concepts may be met in other nursing specialities, the community context of practice means that they present in a particular way and in a particular combination not met elsewhere.

The concepts described so far, *being alone*, *time scale*, *practice agenda*, *uncertainty*, and *visibility*, still fall short of manifesting the nature of the phenomenon of community as a context for nursing practice. One of the criticisms made of nursing phenomenology is that it stops short of the complete process by only giving an account of subjective experience of the participants. There was therefore another level of meaning to access in the research. Taylor (1994) describes reaching a similar evaluation during the process of analysing or interpreting her research. She reports re-immersing herself in her research data which:

> "...created a new fusion of horizons." (p61)

Interpretation revisited

In relation to interpreting concealed meanings, Crotty (1996) advises :

> "...the interpreter has to go beyond what is directly given. In attempting this, he has to use the given as a clue for meanings, which are not given, or at least not explicitly given. " (p33)

By re-immersing myself in my data and reading a range of literature, a new level of understanding developed as if yet another layer had been peeled away allowing me to understand more acutely.

Defining features of practice in the community context are that:

> "communication is more real than in hospital you can't tell patients what to do as you do in hospital " [stfg2]

> "we're about helping people to live with their health problem" [chnfg3]

> "out here they [patients] are in charge, we fit around them, not them around us" [chn2]

> " ...you are not dealing with just one thing at home, you are dealing with a multitude of things at once, like in hospital - although they talk about holistic care, the through-put is so quick and they only see part of the patient - you have the operation or whatever and you're home - once you're home it's not just the cholesytectomy that's the problem - like the man I saw today - so many other things came out - its not just a matter of wound healing, but all the other things that are affecting that mans life." [chn10]

By listening again to what the data was saying and dialoguing with the data and the literature, two important and closely related issues became clear and allowed me to better describe the phenomenon of community nursing:

- Accommodating to the patient's life - preparing practitioners to accommodate the patient's life rather than being focused on the patient's illness or problem is one of the educational challenges of the community context.

- Patient participation in their health care experience - this concept helped to make sense of many of the issues raised in this research; *relationships, power balance, time scale, role boundary blurring, negotiation*. Facilitating and

practising to a patient participation perspective provides an explanatory framework for practising in the community context. However, it helps to make sense of the process, not the phenomenon itself.

The phenomenon of nursing in the community context

The nature of nursing in the community context pivots on nurse participation in patients' lives. This is the 'being' of community nursing and the dimension that sets it apart from other aspects of nursing - providing nursing care while participating in patients lives, in their own homes and in their localities. An important element of the education task is to empower nurses to practise in this environment.

In order to manifest the phenomenon the questions posed in order to direct the review of the literature for this research will be raised again, but answered drawing on the meanings and understanding derived from this phenomenologically directed enquiry.

- What is there to understand about nursing *in the community context?*
- How can education be approached - what are the educational challenges?
- What is the purpose of practice placements?
- How can nursing be researched?

WHAT IS THERE TO UNDERSTAND ABOUT NURSING IN THE COMMUNITY CONTEXT ?

The theory implicit in nursing is not well established and this represents a deficit in our awareness of what there is to learn or understand. This is particularly so in relation to nursing, and learning to nurse, in the community context. By adopting an ontological perspective this research has provided access to descriptions of CHN and student experience of nursing in the community context that widens our understanding of knowing. CHNs and students constructed different versions of reality. In particular the research showed that there are differences in the interpretation frames used by CHNs and students in making sense of their worlds. Schon's (1992) 'naming and framing' concept appears to offer an appropriate device to explore what there is to understand and the differences between students and CHNs.

Nursing in the patients home - what does this really mean?

Van Manen (1990) directs the phenomenological researcher to search 'idiomatic phrases because they:

> "...proceed phenomenologically: they are born out of lived experience." (p60)

A phrase met repeatedly during the research, used by both CHNs and students, was:

> "You have to remember that you are in the patient's home" [stfg2]
>
> "We are a guest in the patient's home - we mustn't forget that" [chnfg4]

The meaning seemed transparent and obvious. However, the meaning of this phrase actually required 'mining', although its relevance as an excavation site was not realised until this stage in the research. Silverman (1994) makes reference to Wittgenstein to describe a similar scenario:

> "The aspects of things that are most important for us are hidden because of their simplicity and familiarity." (p184)

McIntosh (1981) raised the impact of being a 'guest in the patient's home' in relation to the impact on nurse/patient communication and passive/assertive role negotiation. My research has shown that the impact is multi-dimensional and detailed exploration is crucial to illuminating the experience of nursing in the community context. In this research, CHNs seemed to be using this phrase - 'guest in the patient's home' - as short hand to describe a philosophy where practice is negotiated with the patient and where the patient as well as the nurse has control in the relationship. On reviewing the data from all the phases of the research it became apparent that students also used the comment, although it appeared that they were repeating a phrase said to them without really exploring its meaning, despite this being crucial to making sense of the experience. Students gave rather closed and superficial interpretations of 'being in the patient's home'. For example in a focus group one student said:

> "I wouldn't say I learnt any new skills, just to be neater, you have to be in someone's sitting room." [stfg2]

In other words, spilling something on the floor in someone's home means that it stains the carpet rather than pooling on the treatment room floor in hospital. These comments fit with the situation identified by McIntosh (1996) - that someone

unaware of the intricacies of district nursing may only see a set of tasks. The issues highlighted or, perhaps more importantly, not highlighted by the students, appear to be guided by what Rolfe (1996) refers to as traditional, physical care giving, the procedural definitions of nursing. There was a level of complexity and meaning in the situation of which students were not aware. They appear to be merely looking rather than seeing (Eisner 1991).

One of the basic tenets of community practice had apparently been too transparent for both CHNs and students to be alerted to the significance of this phrase - 'being in the patients home'. In order to understand nursing in the community context the meaning of the phrase must be made explicit. Indeed there is a general need to make the detail of practice more visible to both the CHNs and the students.

Nursing in private

An important dimension of 'being in the patient's home' is *'nursing in private'*. Darbyshire (1994b) titles his discussion of parents' participation in the care of their child in hospital 'Parenting in Public': the idea being that private caring was now being practised in the more public arena of the hospital. This private / public distinction triggered the notion of 'nursing in private' to describe nursing in the community context. It is private in the sense that the nurse is alone and the care may not be concurrently shared with another professional. It is also private in that it takes place in the patients private domain, their home.

The Oxford Dictionary (1941) defines private as: " not public, secret, confidential." It is perhaps the level of confidentiality available to the participants together with the 'homely' and familiar environment that engenders the qualities of the nurse:patient relationship described in this research:

> "Patients open up and divulge so much, you felt sucked in."
> (Student focus group comment presented in Table 5)

Patient / carer participation

An issue inherent in 'being in the patient's home' and therefore in their 'domain'', but rather obliquely articulated, is patient participation.

This complex concept is defined by Brownlea (1987:605) as :

> "...getting involved or being allowed to become involved in a decision-making process"

Kirk and Glendinning (1998) describe patient participation in care as a move from 'patienthood to partnership'. Patient participation is enabled or facilitated by a flexible and egalitarian approach, role negotiation, development of a relationship, and surrendering of some control by the nurse (Waterworth and Luker 1990, Jewell 1994, Cahill 1996, Kirk and Glendinning 1998).

Although a popular concept in health care, Cahill (1996) describes patient participation as an elusive concept:

> "It has not been adequately articulated or clarified and remains one of the least understood ideas used by nurses in clinical practice. The eclectic nature of the concept has also resulted in practitioners having only a cursory understanding of what patient participation is." (p563)
> ...

> "...it would appear that patient participation is a modern day icon in need of closer examination." (p563)

Jewell (1994) suggests that there is a dearth of research exploring patient participation from the practitioner perspective. CHNs in this research appear to be practising within a patient participation perspective. Describing their work and the educational implications raised in this study may assist in clarifying the concept of participation generally.

The concept was referred to in a variety of guises. One example was given during a practice narrative discussion:

> "A lot of community nursing is about partnership - if you are doing a care plan you do it in partnership with the patient, the family, their partner, neighbours, friends - you have to, you can't make someone do something - sometimes you have to meet them half way - at least half way." [chn14]

> "Is that any different to care planning in hospital ?" [researcher]

> "In hospital you might include the patient, but in the community this is the patient's life, in hospital that's not their life. That's an acute exacerbation of a problem, when they come home this is living and so if they want a bath everyday, it's pointless putting dressings on that aren't waterproof.. .or if you know someone is going to scratch their leg or put something on that will allow them put their wellies on and go into the garden because you know they are going to do that..." [chn 14]

Students' limited understanding of the concept of patient participation and the inherent moral dilemma between beneficence and autonomy appeared to create some dissonance for them in the practice setting. For example, CHNs reported many instances of negotiating their practice with the patient, or advising the patient, but allowing them to have the 'casting vote' in the decision. They did this

despite the resulting situation containing elements of risk and uncertainty for them. For example, during a practice narrative discussion the difference between negotiation in hospital and the community was raised :

> "Because we have continual involvement, the thing is you might have lost the battle but you haven't lost the war, the thing is to keep dialogue open...." [chn 3]

> "There's a chap I've been to today who needs to be bathed, he doesn't see himself as dirty so he isn't going to get bathed - but I'll not leave it at that, I'll go back and try again and just ask how he is getting on, I've also left my number for him to contact me before then if HE decides he wants me - in hospital a dirty patient would just be bathed / deloused whatever, - no messing." [chn 6]

However, in recounting other situations where the CHN does not impose a decision on a patient, students experienced this as a weakness rather than a practice philosophy. They used phrases like:

> "She [CHN] always seems to back off from a challenge with the patients - they don't do what she says and she doesn't really challenge them on it she just accepts it. [stfg2]
>
> Yes, I know what you mean, they often seem to give in to the patients" [stfg2]

Students appear to frame this aspect of practice using the compliance concept they have met in the hospital setting. The patient participation concept as it is met in the community is not used in their framing process. Being able to hand over some control and work in a more balanced, dynamic relationship with patients is not recognised or apparently valued by students. What counts as nursing knowledge in the students' eyes appeared to revolve around emphasising the distinction between nurse and patient and high-level knowledge being demonstrated in the ability to perform complex technical tasks. The students acknowledged that

CHNs were generally good communicators and that communication was valued in the community, but this was not translated into valued nursing knowledge.

The visibility of the practice knowledge involved in caring appears to be poor. Part of the problem in developing the appropriate frame to understand practice is that students only see a snap shot of the whole intervention i.e. they may not see the next stage of the negotiation and unless the CHN highlights it for them they may not be aware that it will take place. The outcome of the intervention may therefore not be visible to the student.

Sharing care

Another aspect of participation that is frequently encountered in community practice is participation of or with informal carers. Role boundaries have to be negotiated to accommodate a variety of situations. In many instances we are actually talking about substituting some aspects of formal care with informal care. When care needs are assessed, the availability of family or informal carer support has a significant influence. A similar scenario exists in paediatric nursing where if they are available, parents may provide a large part of a child's care. However, in their absence this care is given by a formal carer. During the observation phase of this research I visited a number of patients where the care was shared between CHNs, other nurses and family carers.

One visit was to a disabled middle aged man. On this occasion the CHN and a first level nurse bathed, toileted and dressed him. On some days it was usual for the patient's wife to substitute for the CHN or the first level nurse and at other

times during the day, the wife took responsibility for these care needs. In this instance the boundaries of formal and informal roles are blurred. Any power or authority afforded the nurse as a consequence of possessing particular skills or knowledge is also challenged. This situation could be interpreted as a complex, negotiated situation essential to encouraging self caring or family caring. The practice agenda may be different with every patient and may be dynamic with each patient. The nurse could be seen to be involved in empowering patients and carers and facilitating high levels of patient and carer participation. Viewed from a different angle, this scenario could be seen as a threat to nursing and erosion of the role. Students did express frustration at carrying out activities that could also be carried out by informal carers:

> "A lot of it is basic, we seem to spend a lot of time doing what the relatives do another day, it seems wasteful - I know we're also checking that everything is all right and that the relative is coping, but it still seem wasteful some days." [stfg3]

Cahill (1996) offers two contrasting interpretations of scenarios where activities normally sited within the sphere of nursing, were handed over to patients or informal carers. She identifies one interpretation as 'deprofessionalisaton'. This appears to be the framing used by students. Empowering or facilitating patients or carers to participate is an alternative interpretation.

Darbyshire (1994b) identified that nurses in his study :

> "...described a tension wherein they recognized the importance of allowing and encouraging parents to undertake more of their child's care, but also recognised that this could seem diminishing in their sense of self as nurses." (p208)

However, this research had identified that there is insufficient illumination, to the extent of invisibility, in relation to this aspect of practice in the community context.

Practice framework

Distribution and negotiation of control and patient participation therefore appear to be important concepts in community nursing practice. These factors are manifest in the framework organising CHN practice. Figure 31 provides a model for understanding the organising framework of practice in the community setting. Nine potential types of need assessment are identified :

- no need identified
- further assessment required to establish need level
- need identified by CHN, patient and carer
- need identified by patient but not CHN
- need identified by CHN but not patient
- need identified by patient but not carer
- need identified by carer but not patient
- need identified by CHN but not carer
- need identified by carer but not CHN

These different types of need and need awareness are probably met in other nursing situations in different care contexts. However, what distinguishes nursing in the community context is the presentation, combination and response to these needs.

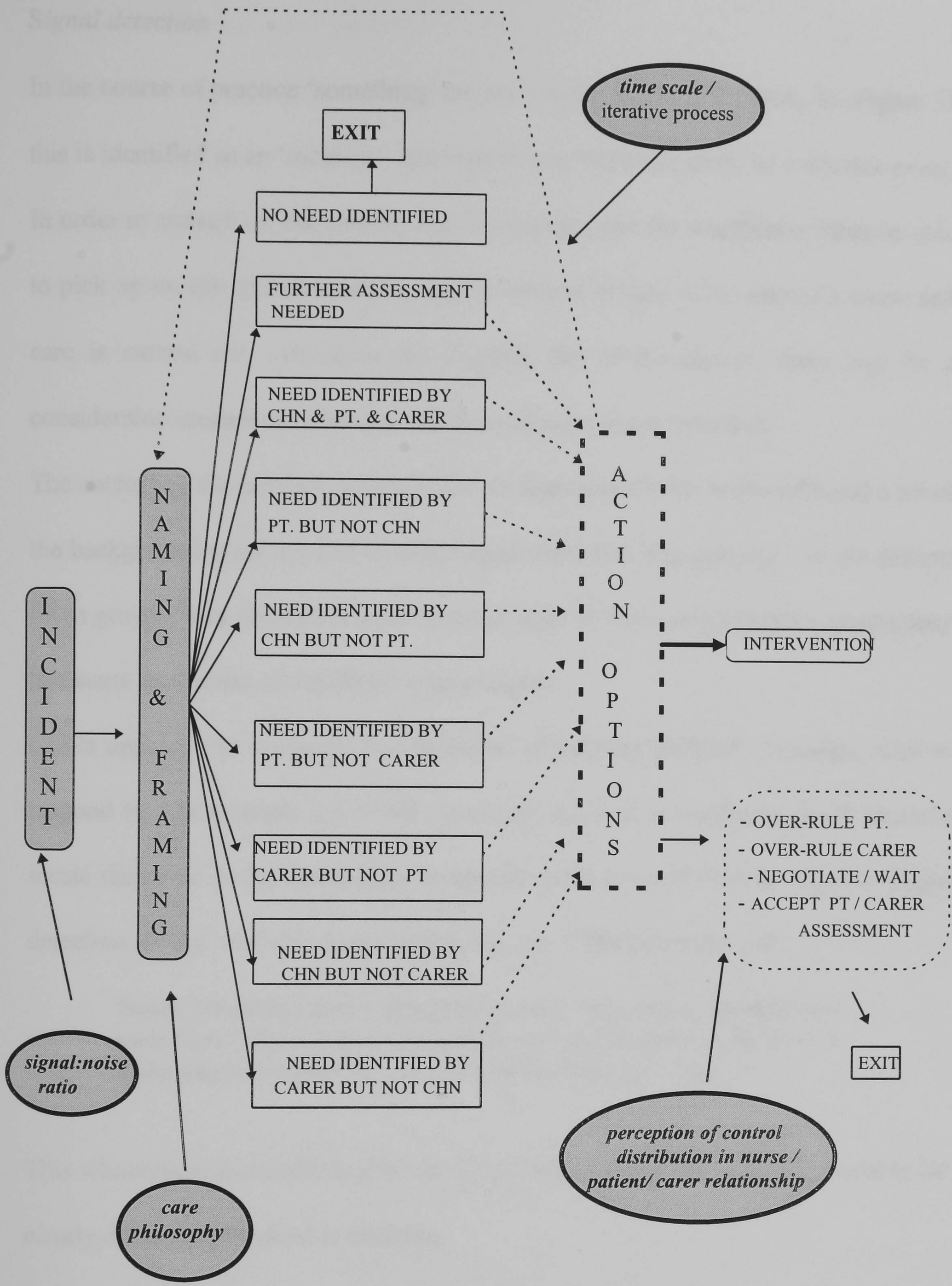


Figure 31 Organising framework for understanding practice

Signal detection

In the course of practice 'something' occurs which triggers a response. In Figure 31 this is identified as an 'incident', although it need not necessarily be a discrete event. In order to embark on the naming and framing process the practitioner must be able to pick up on the relevant signals. As the context of care is the patient's home and care is carried out alongside the ongoing life of the patient, there may be a considerable amount of noise that could complicate signal detection.

The context of the hospital is seen by the students and CHNs to have filtered a lot of the background noise out and to make signal detection less complex. In the student focus groups, they referred to a pre-hospital layer of decision making suggesting they had some awareness of a different type of signal.

CHNs appeared to be aware that students experience difficulty knowing what to respond to. For example one CHN described students as having to search more to locate their role in the community compared to the hospital setting. Student signal detection ability was also questioned by another CHN when she said:

> "Some [students] aren't prepared to look very much, hospital has made them lazy and they are used to seeing the obvious, because it is obvious in hospital, it's so much more clear cut." [chn 2]

This whole issue is complicated by the fact that the community staff nurse role is not clearly defined and indeed is evolving.

Time scale

Many of the care situations have a past relationship to draw on and they all potentially have a future. Any nurse /patient encounter is therefore seen to be an

episode in a longer term relationship. Assessment and intervention can therefore often have an iterative quality where a 'wait and see' strategy can be employed.

This iterative quality to practice can pose restrictions in terms of limiting what the student experiences. It would therefore appear important that the snap shot experienced by the student is put into the context of the care continuum, again making the invisible more visible. Addressing the visibility of long time scale or iterative interventions has implications for many other care situations for example, chronic care, health promotion.

Control distribution

The action option is influenced by the perception of control distribution in the nurse/patient relationship. The CHNs appeared to be reluctant to adopt the 'over rule the patient' option and in preference favoured the 'negotiate' or 'accept the patient assessment' options. This sharing of control often resulted in CHNs experiencing feelings of uncertainty and risk. The situation is in fact extremely complex and much more than allowing the patient to 'have their say'. As a consequence of the context of practice, CHNs are placed in a position of participating, to varying depths, in the patient's life. The problems of a professional having to cope with this scenario have not been fully realised. Control is shared, but legally, professionally, the CHN stands alone in the relationship. This situation places a new dimension to the concept of team working. This is something more than multi-disciplinary work, it is multi-status work i.e. formal, informal, educated, untrained, person involvement, professional involvement.

The issue of sharing control is also discussed by Darbyshire (1994), although in his study ultimately the control resided with the nurse rather than the parent. In my research the overwhelming sensation was that the ultimate control lay with the patient. This may be the influence of the context of practice on the issue of power/control sharing. I suggest that this is something more than being on one 'home ground' or another i.e. the nurse having more control in hospital and the patient having more control in the home. It also relates back to practising to a 'real life agenda' where levels of passivity and assertiveness are dynamically negotiated in relationships. The difference between hospital and community may be explained by suggesting that the 'false' and 'temporary' environment of the hospital setting imposes a change in the normal dynamics of relationships which is not so vigorously imposed in the community setting. I use the phrase 'not so vigorously' because it is still a professional/ patient relationship and therefore different to a relationship with family or friends. However it is set in an environment where the potential for role and power negotiation can flourish.

Care philosophy

Which signals are judged relevant is influenced by the care philosophy. What is the nurse's business and how should s/he go about it ? The care philosophy has to respond to diverse needs that do not necessarily come neatly packaged and may impinge on each other. The role parameters of the CHN are likewise not easily packaged. As one CHN said:

> "In hospital people know your role, it's not open to negotiation.....but here it's different." [chn 2]

Integral to the care philosophy is the notion of nurse participation in patients lives. There are a number of potential ramifications for both nurse and patient. Different patients will encourage different levels of participation and in different situations nurses offer different levels of participation. The nursing response is not standard, but dynamic in response to the situation. Indeed, CHNs were sometimes uncertain as to what degree of participation they should develop. There appears to be little guidance on this aspect of practice. This deficit is undoubtedly fuelled by the limited acknowledgement and articulation of the dilemmas this aspect of practice generates for those involved.

By virtue of the context of care, CHNs are sometimes exposed to elements of patient's lives which leave no choice but to increase their participation. For example:

> "The practical things like the dressing are easy enough - but once you're in the house you are in another realm of possibilities.." [chn6]

> "Plus a lot of people just because you are going in to take a blood or whatever- they look forward to you going because they have a personal problem they want to talk to you about - it may be that they have a family problem and want to sit down and talk to someone who they feel they can confide in .." [chn 14]

> "Does that tend to happen with someone you have known for a while?" [researcher]

> "Not necessarily - it's more to do with the privacy, that you are sitting in their living room ....[chn 14]

> Does having a student with you make any difference ?" [researcher]

> "Probably, people sometimes, probably more often than not, wait until you are on your own, it depends what it is , others include the student as well." [chn 14]

These comments provide examples of the 'nursing in private' concept influencing the practice agenda.

'Community nursing' - does the title help or hinder understanding ?

An important issue to question is whether the term 'community nursing' assists or hinders understanding of practising nursing and learning to practise nursing in the community. As a consequence of the understanding I have developed through this research, I suggest that the current terminology does little to explicate the detail of the complexity of practising in this context .

A major contributor to this problem is the apparent tendency to use 'context' as an alternative to the word 'location'. However, 'context of practice' is about much more than the location of practice. Addressing this geographical reductionism may therefore go some way to illuminate what there is to understand about practice.

A range of terms have been used to describe nursing in the community context - District Nursing (DHSS 1976), Neighbourhood Nursing (Department of Health 1986), Community Health Nursing (UKCC 1991)), Home Nursing (UKCC 1994). These titles generally cloak the complexity of the core structures of the role. The last term 'home nursing' goes some way to provide a more accurate picture of this branch of nursing, but there is still the potential for geographical reductionism.

The meaning constructions met in this research suggest that practice takes place in the context of 'real life' not the 'artificial' environment context of the hospital environment. A title which captures this would obviously be more desirable. In their research on community experience during Project 2000 programmes, Maben et al (1997) identified a theme of 'nursing beyond the hospital bed'. It is this *context* difference rather than geographical location difference that requires more emphasis and explication.

Some possible options are 'social nursing', 'contextual care nursing' or perhaps to borrow the 'family doctor' title sometimes given to General Practitioners and adopt the title 'family nursing'. One advantage of this title is that it includes the family as a focus of care and may also acknowledge that these nurses respond to and care for a range of family life issues. Considerable weight has recently been given to the last suggestion as the World Health Organisation (Williams 1999) has recently endorsed 'family nurse' as the term to describe the community nurse to meet the challenge of Health 21 (1998) in Europe.

Summary: what is there to understand about nursing in the community context?

This research revealed that not only did students not understand all the practice they observed, CHNs had difficulty in articulating all aspects of the practice curriculum. The meaning of practice has to be mined to reveal the underlying philosophies of patient and carer participation and nurse participation in patients lives.

A number of knowledge dimensions were disclosed in the research, some more easily seen than others. Using Carper's (1978) categories, empirical, aesthetic,

personal and ethical knowledge were revealed. As in other nursing contexts, CHNs draw on scientific, evidence-based knowledge to guide their practice and there appeared to be high levels of consonance between student and CHN in relation to this type of knowledge. This was evident with respect to for example pharmacological, wound care issues.

Aesthetic knowledge, which is responsive and dynamic to the presenting situation was not well articulated by CHNs and often missed or misinterpreted by students. For example, when to become more involved in the patient's life situation, when to continue to monitor a situation rather than exit from it (these issues are developed in Figures 32 and 33 and the accompanying discussion). The diversity of need and care situations appears to enhance the complexity of aesthetic knowledge involved in practice in this context.

In view of the importance of the concept of nurse participation in patients' lives, personal or self knowledge is central to practice. However, as students generally only experience practice vicariously and only participate in an episode of a continuing relationship, this knowledge appears to be particularly difficult for them to perceive. CHNs referral to the need for maturity of personality and life experience as being important to practice in the community context may relate to this type of knowledge.

As a consequence of participation in patients' lives, sharing care and care decisions, and working alone, ethical knowledge is also critical but also rather hidden from the student.

HOW CAN EDUCATION BE APPROACHED: WHAT ARE THE EDUCATIONAL CHALLENGES?

Accessing practice derived knowledge is one of the challenges facing nurse educators and the profession in general. The constructivist approach to knowing and learning appears to offer a productive route to this aim. This involves facilitating learners as "purposeful sense makers" (Erikson and MacKinnon 1991) which itself depends on finding a means to "know how practitioners today discern the meaning of events" (Richardson 1992:24).

A rather neglected issue to date that might also be recognised in education programmes is the context in which learning and practice is to occur. This new challenge has only recently been revealed as a consequence of the movement of health care from the traditional hospital setting to the community context. Developing education approaches appropriate to the context of care provision therefore poses an additional challenge to educators.

This research has identified some of the complexities of nursing in the community context and the concepts that need to be understood in order to facilitate practice in this setting. The research suggests that some dimensions of practice in this context are not well appreciated by students and this raises a number of educational challenges, where the earlier quote from T.S. Eliot seems to have some relevance "We had the experience but missed the meaning".

Students had developed a shared meaning with CHNs in relation to some aspects of practice, but other aspects of practice appeared to be less visible to students as discussed in the *'Visibility'* section of Chapter 6. It may be that the complexity

of bringing about the changes in nurse education (UKCC 1986, *A New Preparation for Practice*) that prepares all first level nurses to practise in the community as well as the hospital setting has not been fully appreciated. The situation needs to be redressed in view of the continuing drive to move the focus of nursing from the hospital into the 'community'. The General Secretary of the Royal College of Nursing is reported to have told a conference audience:

> "...health care will be provided increasingly in the community and by nurse-led units. So great will be the switch from hospital care, with far fewer patients being admitted for treatment, that most nurses will go directly into the community after registration." (Doult 1998)

Hospital and community nursing are not distinct, they have many commonalties, but they also have differences which do not appear to have been adequately recognised. The phrase 'fit for purpose' is commonly used in nursing to describe:

> "...a practitioner who has the knowledge, skills and attitudes to function as an autonomous practitioner within the present health care system." (Rushforth & Ireland 1997)

The achievement of this in relation to 'community' practice needs to be questioned. The maps used to make sense of nursing practice in hospital are not sufficient for nursing in the community context. As a consequence, students can only take limited journeys into the world of community nursing - their map does not allow them to explore the impact of context on practice in sufficient depth.

Educational challenges

A number of challenges exist:

- how to make invisible aspects of practice more visible
- how to make participants in the learning situation more aware of each others practice constructions

- developing understanding of and practising to a patient participation philosophy

- developing negotiation and flexibility skills to allow the nurse to become a participant in the patient's life.

- addressing the problem of experience of working alone being at a vicarious level

These challenges are addressed in this section using the concepts of 'naming and framing' and 'world making'. Possible responses to these challenges are discussed in the next section *'what is the purpose of practice placements'*.

'Naming and framing'

Schon's (1992) 'naming and framing' concept serves as an appropriate description for some of the activities that take place during nurse education. Students are provided with frames of reference, a menu from which they select concepts to make sense of their experiences. This research suggests that the menu appears to be weighted towards propositional rather than practice knowledge and the hospital as opposed to the community context.

Goodman's (1978) discussion of ways of world making discussed in Chapter two further clarifies the situation. CHNs and students see different things or select different signals for attention. What drives the selection process appears to be highly influenced by the care philosophy and the time scale of the nurse/patient relationship. It may be that the pre-registration nurse education programme needs to develop students' ability to pick up the appropriate signals. Three

specific areas warrant attention:

1. developing learners' receptivenesss to signals - that relate to the art as well as the science of nursing

2. developing learners' receptiveness to the signals met in the community context, including making the invisible more visible

3. developing mentor education curriculum to allow them to facilitate learning

1. Developing receptiveness

Students need to develop their awareness of signals that relate to the art as well as the science of nursing. Referring back to McIntosh's (1996) work it may be that the education system might do a more efficient job by teaching students to appreciate the art of nursing which currently appears to be poorly identified. There appears to be a tendency to be more alert to technical skills or tasks.

This research has been concerned with 'mining' meaning. It would appear that students need to be encouraged or facilitated to 'mine' the experience during their practice placements. For example, refer back to the student and CHN theme trees produced during this research. CHN trees were always more complex than those of the students. In some respects this is as one would expect. However, the trees were describing experience, not necessarily knowledge. The lesson seems to be that an important education task is to develop students' ability to 'experience'.

Nursing practice is a combination of art and science. Damant (1994) suggests that in order to use an organising framework, the framework has to be available and the significance understood. As a consequence of the under-developed articulation of practice meaning and the invisibility of some aspects of practice,

students and practitioners need further guidance to begin to learn how to decode the detail of their experience. This is a major deficit in an education approach that favours experiential learning.

In order to address this issue, the profile and value of practice knowledge must also be raised in the practitioners' eyes so that they feel empowered to draw on and share this type of knowledge. A precursor to this lies in developing their ability to articulate what they know and the research strategies used in this study, focusing on lived experience and narrative descriptions, may offer some suggestions on how this may be approached.

2. Developing receptiveness to signals met in the community context

Students need to develop their awareness and receptiveness to signals in the community context as well as the hospital context. They currently appear to have more confidence with the hospital frame of reference and often use this framework to make sense of their community experiences. We need to recognise that care terrains are different and students may need more than one map. As the context of care in the community is the patient's home, and care is carried out within the ongoing life of the patient, there may be a considerable amount of extra 'noise' which could complicate signal detection. The signal : noise ratio in hospital may have considerably less interference as a lot of the 'background noise' may have been filtered out by virtue of the context.

What appears to be happening in relation to learning to nurse in the community context is a degree of what Cell (1984) refers to as dysfunctional experiential learning. In this instance experience is manipulated so that it makes sense according to our current belief and knowledge. Several examples were raised in the research. Students at times struggled to legitimise what they were experiencing or observing as 'nursing'. The nursing they observed in the community did not follow the same framework as the nursing they had observed in hospital. Rather than think 'this is different', students tended to say 'this is not nursing', 'this is straying from nursing'. An important issue in causing this dysfunction appears to be students' lack of awareness of the notions of patient participation and nurses' participation in the patient's life.

As Eisner (1991:17) said:

> "If our perceptual experience is aborted for the sake of classification, our experience is attenuated, we do not experience all that we can."

Figures 32 and 33 provide comparisons of student and CHN practice narratives giving examples of possible attenuation. Figure 32 refers to the narrative presented in Figure 26 and Figure 33 refers to the narrative presented in Figure 27.

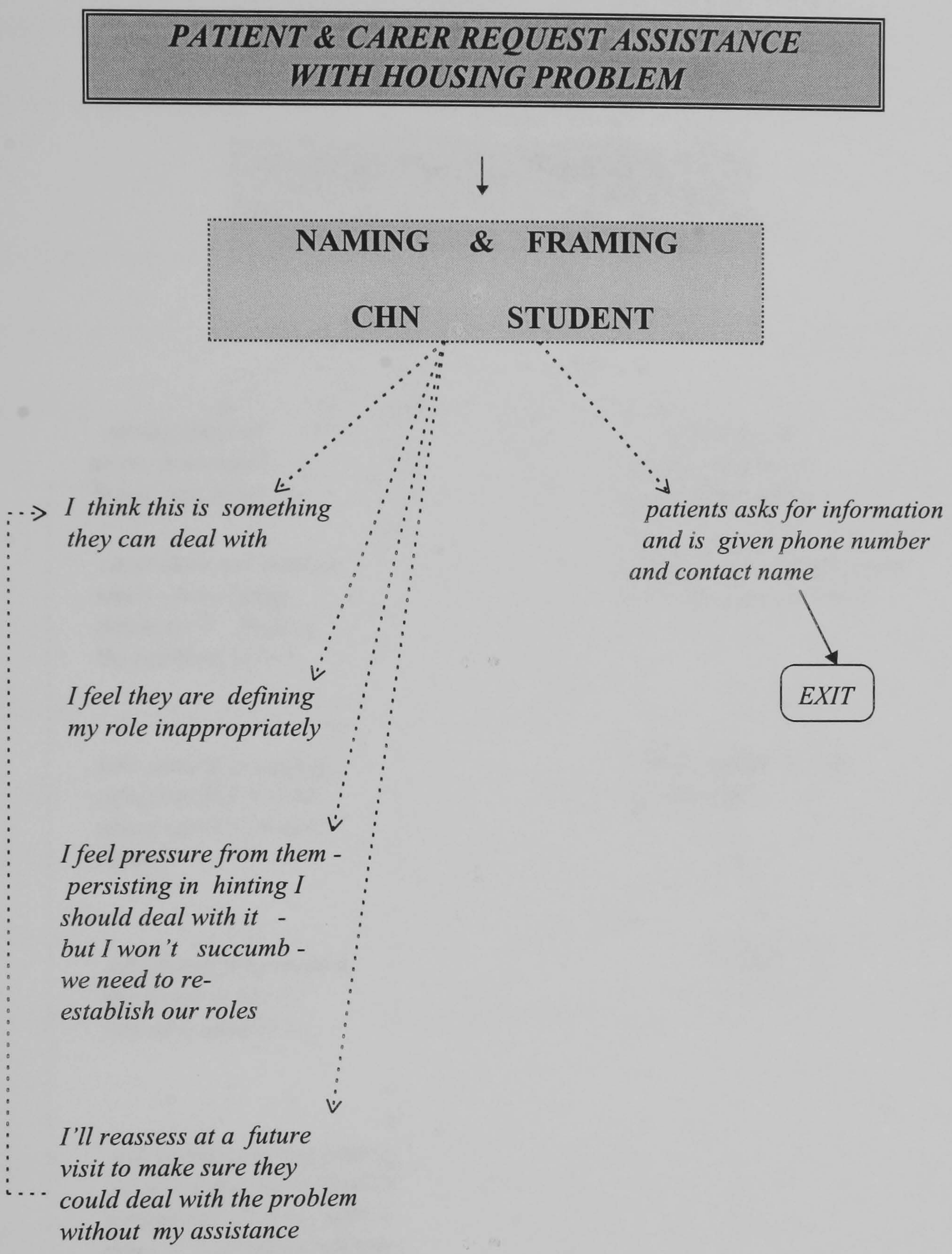


Figure 32 CHN and student 'naming and framing' of the same events

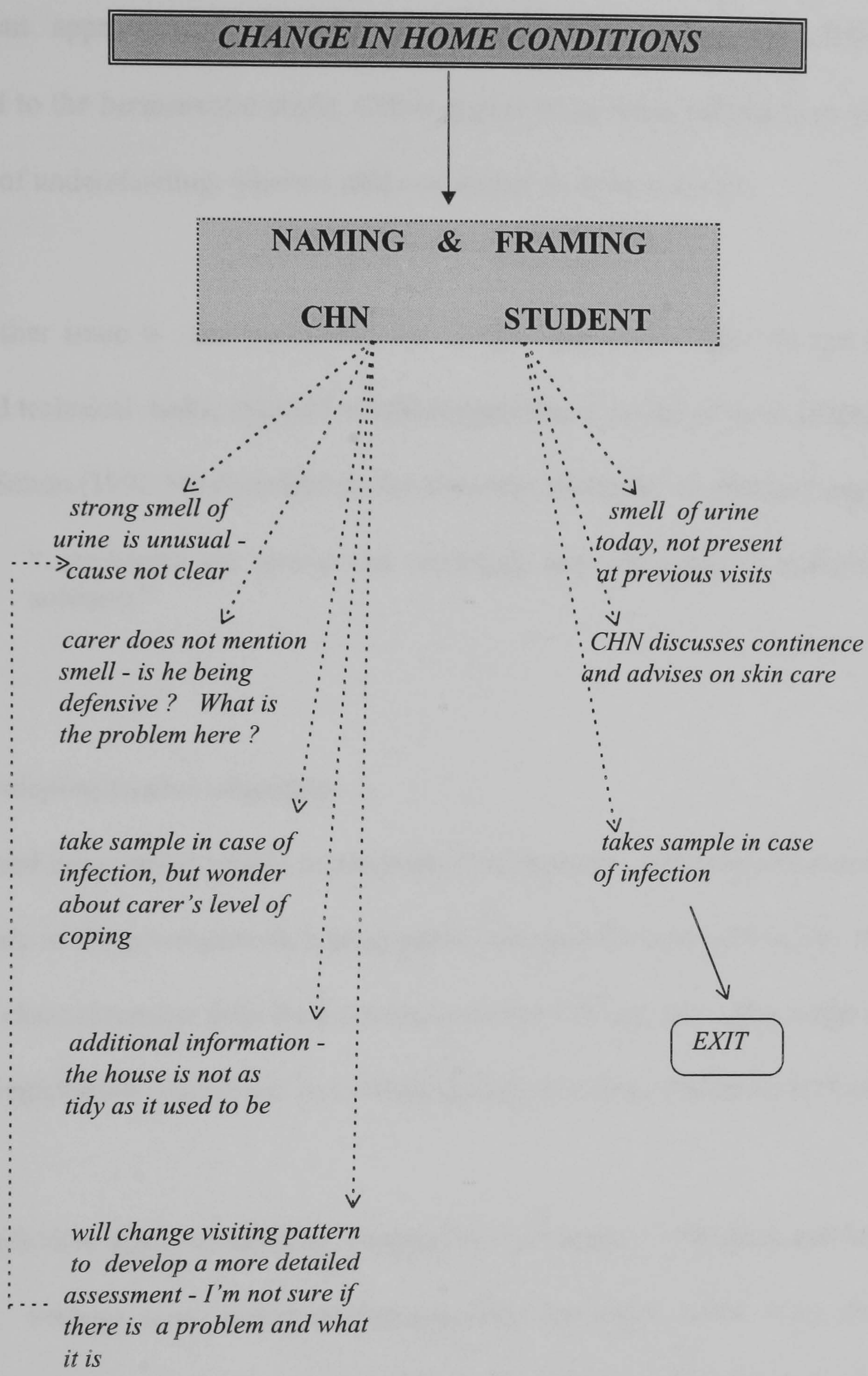


Figure 33 CHN and student 'naming and framing' of the same event

I wish to highlight two issues that are evident in both these examples. Firstly the different approaches to naming and framing taken by student and CHN can be related to the hermeneutic circle. CHNs appear to be more willing to re-enter the circle of understanding, whereas students appear to enter and exit.

The other issue is the reason for the CHNs' dilemmas. They do not revolve around technical tasks, indeed I would suggest that they are more in keeping with what Schon (1992:54) described as the 'swampy lowlands' of practice where :

> "...problems are messy and confusing and incapable of technical solution."

3. Developing mentor education

The third issue raised related to preparation of mentors. The role of practice teacher, certainly in the pre-registration programme has recently been effected by the demise of the clinical teacher role. As a consequence the CHN or any other nurse mentoring a pre-registration student has to increase the educator role within their clinical role.

Learners have been identified as 'purposeful sense-makers' (Erikson and MacKinnon 1991). Perhaps sense-maker or sense making facilitator would aptly describe the practice education role.This may be how the value of an educator with clinical experience in the setting in which the student is learning may be revealed. They have developed their ability to identify and interpret signals met in that particular context - they can then facilitate learners to develop their receptiveness and mentors

to articulate the substance of the process. In this way Eraut's (1994) challenge of higher education:

> "...enhancing the knowledge creation capacities of individual and professional communities" (p57)

may be met.

Summary : how can education be approached ?

The findings of this research give some support to the assertion made by Schon (1987) that :

> "What aspiring practitioners most need to learn, professional schools seem least able to teach." (p8)

Maybe part of the problem is that the approaches used to educate nurses and practice professions in general, have been too loyal to the technical-rationality paradigm. Nurses have not been encouraged or assisted to discover and articulate their practice knowledge. Education could therefore be enhanced by developing the ways and means to articulate and share multiple expressions of knowledge. As Smith (1992:52) said:

> "What one comes to know through the process of learning evolves from the thought that goes into efforts to construct meaning"

The activity of meaning construction as an education strategy needs to be addressed and research such as this guided by the interpretive paradigm will allow this knowledge to emerge.

Some potential responses to the education challenges identified in this discussion are addressed in the next section.

WHAT IS THE PURPOSE OF PRACTICE PLACEMENTS ?

Simply stated, the purpose of the practice placement is to experience and learn about nursing. The task of the educationalist, whether lecturer or practitioner, is to facilitate student access to and construction of the meaning of practice experience. The measure of placements must therefore not primarily be seen in terms of quantity, but rather the quality of engagement with the meaning of practice which takes place. In relation to nursing in the community context, we really need to question whether students do actually experience this type of nursing and if they do not experience it or only experience it vicariously - then what do they actually learn .

Benner, Tanner and Chesla's (1992) model of learning-in-practice portrays the learner as moving from detached observer to being fully engaged in practice. Relating this to the data generated in this research may help to explain why CHNs consider that :

> "Students don't see all the layers of practice." [chnfg1]

If a central tenet of community nursing is meeting the practice situation alone, students generally only experience this vicariously and there must therefore be a layer of practice they cannot appreciate and indeed may not even be aware of. One of the CHNs actually said that she had not fully appreciated what practising alone meant prior to moving from the hospital environment :

> "...in hospital you check so many things, not just drugs, without really knowing it- don't realise until you come out here and there's no-one to check with how much you actually rely on checking." [chn 1]

The result could therefore be that students primarily see the task performed and cannot fully appreciate the contextual implications because they do not experience the full impact of the practice context. It may be that the vicarious nature has to be accepted, but acknowledged as a new learning agenda when a first level or even a specialist practitioner qualifies.

Giving meaning to practice

According to Berger and Luckman (1967):

> " ...reality exists because we give meaning to it ."

Comparing the meaning given by students and CHNs to mutually experienced practice episodes for example comparing Figures 32 and 33 or areas of consonance and dissonance presented in Figure 19 suggests that 'reality' for student and CHN may be different because their meaning constructions are different. When they engage in 'world-making' (Goodman 1978) different versions of the world are produced. This concurs with Benner, Tanner and Chesla's (1992) assertion that novices and experts 'live in different worlds'.

The meaning we construct from our experience is dependent on our meaning construction tools or abilities. McKee's (1991) discussion of humanism and nursing is drawn on to develop this idea of meaning construction facilitation. She suggests that an essential ingredient for a humanistic approach to practice is that :

> "...the nurse must herself approach nursing as an existential experience. Nursing is itself a lived experience, a response to a human situation which the nurse shares with another. It involves a transactional relationship, the meaningfulness of which requires that the nurse has a conceptual awareness of self and an acceptance of the uniqueness and value of the other." (p175)

It ought to be feasible to apply this to the CHN/student relationship. The term existentialism developed from the Latin verb *existere,* 'to stand out from, emerge or become' (McKee 1991:172). Adoption of this philosophy may facilitate a fusion of teacher and learner horizons and may facilitate the giving of meaning to practice.

This philosophy may also have relevance to facilitation of the principle of 'life-long' learning, clinical supervision and periodic registration portfolio data.

Student and CHN interaction

The interaction between CHN and student needs to be explored to identify what is shared. Sellappah et al (1998) consider 'questioning' as a teaching strategy during clinical placements. They found that low level questions were generally posed by clinical teachers. They concluded that one reason may be that the clinical teachers had not been taught how to ask higher level questions. Another dimension to the verbal interaction between student and clinical teacher was highlighted by Fish, Twinn and Purr (1991). They found that clinical teachers tended to refer students back to their store of propositional, codified knowledge to explain practice situations. Sharing their own construction of the practice situation was not the usual action. Consideration of these studies allowed me to identify two issues for attention: First, what type of communication strategy should be employed when teaching in the practice setting? Secondly, what should be the focus of the communication ?

Despite CHN's perceptions of a level of dissonance between their own and student nurses views of practice e.g. 'students don't understand all the layers of practice',

'students don't fully appreciate the CHN role', during the practice narrative discussions they were often surprised at the difference between the CHN and student 'story'. This appeared to provide them with a new insight into the student world of understanding. It allowed them to develop a different appreciation of what students experienced and understood during their practice placement and provided a different dimension to the learning agenda.

In discussing the practice narratives presented in Figure 26 CHNs were disappointed that this student had perceived the visit as primarily focusing on applying cream to the patient's skin:

> "We don't just go in to apply cream, I mean I might say that to another CHN, but it's a sort of short hand, they would know it was more than just a skin application - I wouldn't go in for that..." [chn 3]

> "It doesn't really explain what it's all about ... but I can see how the student could think that if it wasn't explained to them and I don't know if I always would explain - you can't explain everything..." [chn8]

> "You need to talk more - why did I do that, what did I talk about and ask them about and why - what was I chatting about - otherwise they could miss what's going on - like in the first transcript - go in, do the cream, go out" [chn 3]

> "Do you meet similar scenarios in hospital where the student might only get a portion of the picture?" [researcher]

> "In hospital if someone comes in with say bronchitis then you treat the bronchitis and the other things are managed somehow and as long as you get the bronchitis sorted out - then they go home and then the bronchitis is a part of the whole life rather than the focus of the picture - I'm not trying to knock hospitals, but they see different people." [chn 3]

> "Most of these narratives tell me that students don't perhaps fully understand what we are about - if this is what they are interpreting - they aren't fully understanding what community is about." [chn 8]

CHNs had raised the issue of students not 'seeing everything' during the focus groups :

> "You could sit in the background and let the student do the dressing, but they wouldn't have a clue about all the other things. [chnfg2]

However, it appears that the practice narrative comparisons helped the CHNs realise why this was the case. For example, the short-hand language they describe may be understood by their peers, but not by students. This language has insufficient depth or cues for a student to realise the complexity of their actions. It has to be decoded to be more effective.

This may be similar to the 'cultural isogloss' between tutors and students described by Burnard (1991) - an isogloss being "the line of demarcation between 2 languages". This research suggests that a similar situation exists between students and practitioners. In a discussion of adolescent/adult talk Baker (1982) identifies a similar problem of "knowing how to design our talk for others" (p105). In relation to the notion of 'social placement' he goes on to say:

> "Members of any culture or social world share ideas concerning what persons at various points in life typically could be expected to know...and what their capacity for understanding and making sense of things should be." (p109)

It is apparent that greater attention needs to be devoted to developing student/CHN interactions, and 'designing our talk' to facilitate learning in the practice setting. In view of Bousefield's (1997) suggestion that :

> "Nursing is not a unitary society with a common value system, it is a pluralistic society with a variety of value systems." (p253)

the 'isogloss' issue may infact be active between a variety of nursing settings and specialisms.

Facilitating learning in the practice placement - some suggestions

Learning in the practice placement may be facilitated by addressing both the content and process of learning.

The practice placement provides opportunities to use and develop a variety of forms of knowledge. Some learning experiences are common to many contexts i.e. aseptic technique, assessment, patient education. However some contexts may offer particular types of experience that set them apart from other contexts. Alerting students to these learning opportunities appears to be an important starting point. For example, of particular relevance to community practice is the concept of patient participation. Exploration of practice constructions also raises the complementary concept of nurse participation.

I would like to propose 'dialoguing' as an appropriate approach to practice education. In view of what appear to be hidden aspects of practice, a crucial focus

for the dialogue between student and CHN is : 'Do you see what I see'? The dialogue which results may then provide a realistic learning agenda.

Education could therefore be developed by enhancing the means to articulate and share multiple expressions of knowledge. Curriculum could be partly determined by bridging areas of consonance and reducing areas of dissonance or at least acknowledging an appropriate dissonance i.e. knowing what we expect from first level, specialist and advanced practitioners.

Bousefield (1997) suggests that dialogue about the individual's world may be a means of accessing the constructed meaning of experience. A similar notion is encountered in the concept of *dasein*, that an activity (nursing) can best be articulated in practice. The experience of using the 'narrative' strategy in this research supports Bowle's (1995) assertion that :

> "...storytelling is an accessible yet powerful tool which contextualises and humanises nursing knowledge, facilitating a deeper understanding of self and others." (p365)

Story telling may be particularly suited to community nursing practice for two reasons. First, the episodic practice format, where the start and the finish of each visit is clearly delineated. Unlike hospital based nurses, the CHN is not potentially involved with the patient for the full working day, but the time period of a visit. Secondly, Richardson (1997) also highlights that since CHNs usually work alone they naturally engage in recounting their experiences in whole episodes to colleagues on their return to base.

However, the value of narrative in the eyes of the practitioners may have to be raised. Its place in the hierarchy of knowledge forms appears to warrant greater support. The participants of this research needed considerable reassurance that their words were worthy and their knowledge presented in this format credible. Fish (1989) showed how practitioners seek to legitimate the conceptual basis of their practice by referring students to 'scientific' theory. These ideas are being challenged by post-structuralist views on knowledge. Imposing meaning onto experience is essential for learning and understanding the knowledge base of a profession.

Narrative seemed to serve the same function as the photo-fit picture in describing the detail of practice and unearthing the distinguishing features of nursing in the community context. The outcome of this research supports the assertion made by Heinrich (1992):

> "When nurses share their experiences in the form of stories, both the storyteller and the listener are nurtured. A sense of community is created, reducing the invisibility and isolation of nurses' daily practices. " (p141)

Summary : what is the purpose of practice placements ?

Learning in the practice setting has a lot in common with the ideas expressed in Goodman's (1978) ways of world making. The findings in this research study appear to give added weight to Nehls's (1995) discussion of narrative pedagogy as an approach to rethinking nurse education. She describes it as a way of :

> "...of thinking about teaching and learning that evolves from the lived experience of teachers, clinicians, and students." (p204)

Benner's contention that novices and experts live in different clinical worlds also appears to have substance in this research. Now that this differential has been acknowledged, some means of bridging the divide must be sought and narrative pedagogy or dialoguing appear to be very appropriate options. The teaching/learning relationship needs to be addressed in order to allow the participants to share each others practice worlds. Dialoguing between the parties appears to be an effective way of accessing the practice world and the specific learning opportunities it provides.

HOW CAN NURSING BE RESEARCHED ?

There are many options available to the researcher and the choice of research strategy is dictated by the type of question being addressed and characteristics of the research site. This research aimed to broaden our understanding of nursing and learning to nurse in the community context. It aimed to go beyond achieving a description of the practice of nursing in the community context but to 'envision' nursing practice. This follows Eisner's (1991) suggestion that the naturalistic paradigm allows us to access a level of data that can broaden our understanding of what it means to know. Van Manen (1990) specifically identifies phenomenology as a perspective which:

> "...consists of reflectively bringing into nearness that which tends to be obscure, that which tends to evade the intelligibility of natural attitude of everyday life." (p32)

There were two main aspects to accommodate in this research:

- accessing accounts of experience of nursing
- the context of practice

Accessing accounts of the experience of nursing

The process of accessing this level of meaning required methodological development. One of the challenges of the research was facilitating the participants to discuss their practice experience at this level. As other researchers had already found, simply asking for this information did not produce the desired level of articulation. Participants were more inclined to give a description or account of the product rather than the experience of the process of their practice. The detail of their practice experience was shrouded in descriptions and words that did not actually convey the richness or meaning of the experience. In the literature review, reference was made to this situation drawing on Rolfe's (1998:30) example of a plumber's bill for a 30 second job of hitting a pipe with a spanner:

> "Hitting central heating pipe with spanner £1
> Knowing how, when, and where to hit it £99"

Research participants in this study were more ready to give the £1 version of events. For example when discussing the impact of context on practice a repeated comment from CHNs and students was along the lines of "you have to remember you are a guest in the patients home". What this actually *meant* - the £99 version of events, was much more difficult to access. Even when an interpretive approach is adopted Benner (1994) warns that :

> "...beginning interpretive researchers and participants have to be coached to generate narrative accounts because participants may expect to give only "facts" and "opinions". (p108)

The account of the process of this research may enable others to develop their ability to coach participants in the appropriate articulation style. An important message is that it is not a 'one stop' process. It is about 'mining meaning' and

'peeling back layers' - it has to be facilitated. The model developed in this research of articulating the immediate meaning of a practice episode (either in observation with concurrent interviewing or practice narrative recording) and revisiting it in a group setting or in a comparative manner (mentor:student, CHN:CHN) appears to be very useful. At present, lived experience and narrative approaches are often unfamiliar to both researchers and participants and it is only through dissemination of research utilising these strategies that more confidence will develop.

In reviewing other research when planning this study, Hamill's (1994) comments were informative:

> "Nurses can only start to understand a patient's view of things by actively inquiring into a patient's lived experience." (p511)

The same sentiment could be applied to trying to understand the meaning of nursing practice - lived experience must be the focus of the research endeavour.

It takes time

The approach taken in this research was a time consuming and iterative process. It was facilitated by the development of a longitudinal and collaborative relationship between researcher and CHN participants. Both the development of the research design and the interpretation of the data was carried out in collaboration with the participants. The research sought to seek the detail of their experience, it could not be developed or interpreted in isolation to the participants - this would conflict with the philosophy guiding the research. It would therefore be appropriate to refer to a process of data generation rather than data collection.

Being an insider

Can this type of research question be addressed by a non-nurse? I would suggest that experience as a community nurse and an educator were highly influential in posing the research question. These 'insider' roles were probably even more influential in persuading the researcher to continue to pursue the question when challenged by difficulty in accessing more than broad brush descriptions of practice. This was an example of how the researcher could not bracket out previous knowledge or experience. At this stage in knowledge development there is such a paucity of guidance, that personal knowledge was essential. Accepting that difficulty in accessing the appropriate level of data was not a case of, to paraphrase Wittgenstein 'that of which we cannot speak, we must remain silent', two main factors were identified as limiting participants' discourse. The first was the tendency to use broad descriptions with a reliance on propositional rather than practice knowledge.

> "Communication is different to in hospital, more honest" [stfg2]
>
> " Routine may turn out not to be routine - you don't know what you may be faced with - it's something you just only experience out here - I can't describe it ". [chnfg4]
>
> "There are things students just don't pick up on" [chnfg4]
>
> "It's hard to articulate what's different about community, but it is different, very different." [chnfg]

The second factor limiting discourse was lack of established research strategies to guide the process. These had to be developed as the research progressed and the

collaboration and 'fusion' which took place may have been difficult for an 'outsider' researcher.

Being there

A comment made during the first CHN focus group (relating to CHN and student differences) was highly significant for accessing accounts of experience:

> "I know there are examples, I just can't think of one, it's difficult after it happens. But really, you would have to be there." [chnfg1]

'Being there' was an important criteria for this research. It can be interpreted in a number of ways.

The immediate operationalisation of this notion was to physically 'be there' as manifest in the observation phase of the research. The purpose was not simply to observe or watch, that was only one dimension. The other purpose was to 'be there' to be available to dialogue about meaning and meaning construction.

Practice narrative recordings were developed as an alternative to physically 'being there'. This meant that disruption of the care environment was minimalised, an important issue when researching in the community context and one which I will address in more detail in the section *'community context as a research site'*. Of course, this 'being there' at a distance does not allow the researcher to witness or experience the stimuli of practice. This was not an issue for this research as the focus was on individual meaning constructions. However, if the processes and interactions occurring during practice were the focus, physical presence may be required.

Method development

Clearing the hurdle of the participants knowing more than they could articulate required methodological development. Polanyi (1967) refers to the difficulty experienced in describing the features of a face unless provided with some sort of tool like a police photo-fit kit. A 'tool' to assist articulation also had to be developed for the research participants. The tools developed were 'narrative' and 'dialoguing'. Through narrative, the detail of experiencing nursing was exhibited and the discussion groups assisted in constructing meaning from the narratives. The experience echoed that described by Heinrich (1992) who attempted to use story telling as a teaching strategy. Her students' comments demonstrated that their own stories were perceived to hold limited value for them and they were not used to:

> "giving words to their intimate professional experiences" (p142)

When CHNs were comparing student and CHN practice narratives they identified that they thought the CHNs concerned had perhaps continued to use the CHN to CHN shorthand to describe practice. This shorthand or language was not conveying the appropriate meaning to the student. This "giving words to" is essential if the detail of nursing practice and experience is to be revealed. The whole issue of the explication and development of a nursing language is currently being addressed on a European scale (Clark 1997) and this research may contribute to one dimension of this wider issue.

An additional lever to accessing constructed meaning was the use of comparison between CHN and student. The parties in the comparison relationship may in fact be

irrelevant i.e. it could be two CHNs. It is the comparison of two realities that provides the vehicle for dialogue and triggers meaning exposition. The strategy's potential for meaning sharing may extend far beyond the research study itself. It is possible to identify a number of potential uses:

- identifying and exposing qualitative differences in practice understanding which could contribute to the levels of practice agenda i.e. first level, specialist, advanced;

- enhancing multi-disciplinary partnership and understanding by providing a means of sharing practice perspectives;

- as a vehicle for clinical supervision.

Community context as a research site

The context of practice raises a number of issues and offers several opportunities and challenges. Spouse (1997) identifies a number of practical and ethical problems in relation to researching in the clinical area in the hospital setting. My research experience endorsed her comments and identified additional issues by virtue of the community context. Referring to Spouse's work helps to explicate similarities across research sites and as well as the particular characteristics of the community context.

Researching in the clinical area

It is possible for the researcher to be present in the care situation as demonstrated in the observation phase of the research. One of the potential problems for a researcher in the community as opposed to the hospital setting is that their presence is very obvious. There may be greater opportunities to adopt an unobtrusive position in the

hospital environment where there will generally be more people and therefore more opportunities for 'blending' into the general environment.

The very practical issue of physical space is another important dimension. Indeed in the confines of a small room it can be difficult just physically keeping out of the way. Similar problems could be experienced in a hospital environment around a curtained off bed or in a small cubicle. What distinguishes community is that this is the only type of care environment available to the researcher. In the hospital context there is the option of taking a research position in an open ward, although this would preclude some potential research situations.

Spouse (1997) reports to have left 'the scene' while intimate care procedures were carried out. This is an acceptable and very feasible option in the hospital ward. However in the community this could mean either leaving the house and not being able to research any of the subsequent practice with that patient, or the alternative is to leave the nurse and patient and go into another room. This would entail asking the patients permission to move around their home. This could be considered an unacceptable intrusion into a personal and private environment.

Nurse/patient relationship

The CHN usually works alone, so the presence of the researcher turned a dyad relationship into a triad. Negative consequences of turning the usual dyadic relationship into a triad could be that some aspects of the nurse/patient encounter are inhibited i.e. some issues are not shared with a 'stranger'. It is not just a matter of introducing another person into the physical environment, it is about the impact on the nurse/patient relationship. Dyad relationship does not actually fully describe the

CHN/patient scenario - their relationship may have a significant past and future and a certain intensity, depth and familiarity of relationship may have developed as a consequence. It is important to note that the community context as a research site may therefore challenge Field's (1980) suggestion that the researchers presence in the hospital setting is accommodated to the extent that a triadic relationship essentially reverts to the usual dyadic. In her account of research in the clinical area Spouse (1997:189) suggests that her presence might have affected "the social climate.....perhaps more attention to detail or procedures". It must be acknowledged that she was observing learners who may have felt an element of assessment in the observation. However even allowing for this, it is interesting that the impact on the nurse/patient relationship was not raised as an issue. This may indicate that it is an issue of particular consequence for the community context.

Multiple versions of the practice experience

The value of using comparison as a means of facilitating dialogue has already been identified. To achieve student and mentor comparisons a mutually experienced practice episode has to be accessed. In the hospital setting it may be feasible for the researcher to observe patient care at a distance and to then discuss the episode with the student and mentor in a ward office. However, to achieve this in the community context would require the intrusion and inconvenience of three visitors entering a patient's home. Practice narrative recordings appear to be a useful way of capturing the experience of practice from a distance. They also have the added dimension of allowing the researcher to access not only what they might have observed to be

occurring but in addition, access to the world making construction of the participants.

Opportunities for discussion

The very positive aspect of the structure of community nursing, is that between visits the CHN and researcher have a period of time for confidential discussion in the car. A hospital environment would also offer opportunities for confidential discussion i.e. the ward office. However, what distinguishes community is that the pattern of practice i.e. physically having to travel between patients' homes, provides a 'time slot' for discussion which is not taking the nurse away from patient care or disrupting the routine - rather travelling time can be utilised for research purposes. The community as a context of research therefore offers some unique research opportunities.

Working alone

As a consequence of the very individual nature of observation i.e. only one nurse can be observed at a time, the participants have to be committed to facilitating the research because they have to put considerable effort into the process. They are exposing their practice to the researcher for hours at a time. On a more practical level the researcher and participants are physically in the same environment i.e. the patient's home or the CHN's car for several hours. In the focus groups students reported that in the community there was no escape from the patient. The same applies to the CHN - there is no escape from the researcher !

Summary: how can nursing be researched ?

Combining phenomenology and constructivism appears to offer a useful approach to researching nursing and education. Phenomenology provides guidance for the level of meaning i.e. lived experience descriptions and constructivism facilitates building our understanding of the educational challenges.

Exploring this facet of nursing ontologically sheds some light on the nature of knowing nursing in this context. In her discussion of the post-technocratic model of professional education, Bines (1992) identifies that :

> "...it brings a number of new challenges, not least the need to further develop our knowledge of the range of competencies involved in a particular profession...." (p16)

This research offers some contribution to the development of understanding in relation to nursing in the community context.

Phenomenology does not have a long history in nursing. It is probably true to say that the majority of nurses will have limited knowledge or experience of this research approach. There is considerable diversity in its interpretation which creates some tensions for the novice phenomenologist. These issues have been identified as the research proceeded and their solution or accommodation shared with the reader.

Phenomenology has been employed by a number of researchers to improve professionals' understanding of the patients' experience. Hamill (1994) describes it as providing the nurse with:

> "...greater understanding of the patients' perspective on his/her hospitalisation." (p510)

This study has demonstrated that a phenomenological framework can also enhance understanding of 'community' as a context to practise and to learn to nurse. It has highlighted previously invisible issues, such as the visibility of practice and the largely vicarious experience of working alone. By revealing some of the complexity of the impact of community context on nursing practice, the adequacy of the title 'community nurse' has been called into question. Indeed the phenomenon of community nursing can now be viewed with an 'enlightened eye'.

Despite the problems inherent in such a complex interpretive perspective, the approach adopted in this study to articulate the constructed meanings of practice has allowed access to a wider definition of knowing nursing. The extra dimension it offers has research, teaching and assessment implications.

Summary: integration and discussion

According to Koch (1998:1183) "Stories can make nursing practice visible." The use of story or narrative in this research has illuminated the experience of nursing and learning to nurse in the community. The nature of nursing in this context is seen to pivot on nurse participation in patients' lives.

Nursing 'in the patient's home' provides a number of learning opportunities and challenges. Suggestions to address these focus around developing the meaning construction abilities of learners and facilitation abilities of mentors/educators.

The important, distinction between context and location has been highlighted. This dimension of practice and learning to practise has to date received limited attention. In view of the shifting location of health and social care practice, it is very timely to explicate the implications of the community context for practising, learning and researching nursing.

The next chapter concludes the discussion and highlights a number of messages from the research.

CHAPTER 8

SUMMARY

&

CONCLUSIONS

This chapter provides a summary of the research findings and then draws out some messages the research has to offer to a number of contemporary education and policy debates.

'The Study'

This research had a three-fold agenda; the exploration of the constructed meaning of nursing in the community, the clarification of educational need and, in view of the deficit in this type of research, the development of appropriate research processes. The discussion presented in this thesis is therefore not just about the outcome, but equally about the process of the research.

Exploring the constructed meaning of nursing in the community

The constructed meaning of nursing identified in this research challenges the appropriateness of the term 'community nurse ' to described the nurse practising in the community context. It does not do justice to the complexity of practising in this context but focuses attention on geographical location. Practising in the 'community' is not simply hospital nursing outside the hospital. The context imposes an additional agenda on practice. This is evident from the concepts which form the building blocks of constructed meaning of community nursing for the CHNs and students who participated in this study. The context of practice is highly significant and so 'environment of care' is a central issue which has implications for all other dimensions. The five core concepts of 'practice agenda', ' time-scale', 'being alone', 'uncertainty', and 'visibility' each have a number of foci and were found to be interrelated in a number of ways.

Further interpretation of the data allowed the phenomenon of nursing in the community context to be understood more precisely where the nature of nursing is seen to pivot on nurse participation in patients' lives. This adds to our understanding of 'participation', as well as identifying a new dimension to the concept.

'Being in the patients home' was identified as a phrase rich in meaning. A matrix of issues inherent in this phrase - care philosophy, iterative care process, nurse/patient control distribution - are drawn together in a framework for understanding practice presented in Figure 31.

Adhering to the hermeneutic philosophy, where:

> "...texts are interpreted in order to ascertain their essential meaning"
> (Hallett 1997b:416)

the research has exposed meaning and understanding which had previously not been surfaced or articulated. This research has therefore been about peeling back layers of understanding and meaning construction to expose heuristics at the core of practising in the community context. It is an indicator of the 'trustworthiness' (Koch 1996) of the research that CHNs can recognise the issues revealed - it is their constructed meaning and taken-for-granted understandings which have been mined.

The research accords with Polanyi's (1967) view that there are limitations to our ability to express our knowledge. A number of manifestations of this were revealed in the research. When the 'mined meaning' was shared with some of the CHNs they

made comments such as 'I wanted to say that to you earlier on, why didn't I'? The ability to give language to our lived experience is an important factor in developing and sharing understanding of nursing practice. As van Manen (1990) highlights:

> "Ordinary language is in some sense a huge reservoir in which the incredible variety of richness of human experience is deposited. The problem often is that these deposits have silted, crusted or fossilized in such a way that the original contact with our primordial experiences is broken." (p60)

In this research the CHNs felt they had something to say, but had difficulty in doing so. Yet when the 'mined' meaning was shared with them they recognised it as their lived experience. Their constructed meaning of practice has therefore been given a clearer voice.

Clarification of educational need

The lived experience of students and CHNs had many issues in common as well as a number of differences. The research suggests that some dimensions of practice in the community context are not well experienced by students and this raises a number of educational challenges. Some students appear to only take limited journeys into the world of community nursing. The CHNs were disappointed by the deficits and limitations in student learning when student and CHN narratives were compared. During one of the practice narrative discussions a CHN revealed that this was not a new experience for her or her colleagues :

> "I've never forgotten a male student nurse who after he had been with her [CHN colleague] a while stated he could do the job - he didn't know what all the fuss was about - give him a job tomorrow and he could do it and he really was that arrogant about it - we were all up in arms, but then I thought about it and thinking about

> it again now, we are probably letting ourselves down in a way because we are not being explicit....” [chn3]

‘Being explicit’ appears to require facilitation. As a consequence of this research the learning experience of nursing in the community context now has clearer navigational waypoints allowing students to further their journey into this aspect of nursing.

Making invisible aspects of practice more visible and addressing the problem of experience of working alone being at a vicarious level are important issues in relation to learning to nurse in the community. Education could be enhanced by developing ways and means to articulate and share multiple expressions of the practice experience. Narrative seemed to serve the same function as a photo-fit kit in describing the detail of practice and unearthing the distinguishing features of nursing in the community context. Dialoguing between parties appears to be an effective way of accessing the practice world and the specific learning opportunities it provides.

The research process

Hermeneutic phenomenology, supported by constructivism, provided a theoretical framework for the research. An analogy can be drawn with the task faced by Hermes:

> “who had to understand and interpret a multiplicity of messages, languages and meanings from various gods, so that he could translate and convey their meaning to mortals.” (McLeod 1990:75)

In a similar manner, the research drew on a variety of data sources and via their translation aimed to convey the meaning of nursing in the community context. In this respect, Gadamer's (1975) notions of dialogue and fusion of horizons were particularly influential.

Several strategies were employed to access descriptions of the lived experience of nursing in the community: namely focus groups, observation with concurrent interviewing, practice narrative recordings and practice narrative discussions. As a consequence, a number of complementary levels of meaning were accessed and provided a large quantity of rich data. A spiral of collaborative design development and transformation occurred in order to 'excavate' the meaning of experience for students and CHNs.

The community as a context for data collection raises a number of issues: intrusion into patients' homes, impacting on the dyad nurse/patient relationship, mobile nature of practice, practitioners working alone which means only one practitioner can be observed at any time. However, practice narrative recordings appear to offer substantial possibilities to 'be there' *by proxy*, thereby accommodating some of the contextual problems as well as an interpretive dimension.

The process of analysis was guided by the interpretive paradigm. Cognisant of criticism levelled at some nurse phenomenologists (for example incompatibility of analysis process and philosophical underpinning of the research), a detailed rationale for the analysis process was reported. Each phase of the research was analysed both

independently and in relation to meta-analysis dialoguing across phases. Theme trees and mapping were used to display, review and track data. This was a useful strategy to facilitate dialoguing with the data for the lone researcher. Interpretation of the data was therefore an iterative process in line with the notion of an interpretive continuum.

In a discussion on the merits of 'story-telling' as a research strategy Koch (1998) identifies the challenge of:

> "How can these projects move beyond the story to a better understanding, and if appropriate, action." (p1183)

I believe this research has both told the story and achieved a better understanding of nursing in the community context as a consequence of engaging in both textual description and textual disclosure as described by Allen and Jenson (1990).

For pragmatic reasons the interpretation process has been 'artificially' drawn to a close. The interpretation process has not actually come to an end - indeed it is difficult to conceive of an 'end-point'. This is a consequence of following this research paradigm - each time the hermeneutic circle is re-entered the interpretation may undergo further transformation. The 'fusion of horizons' is a dynamic process with the potential for the landscape to become ever more detailed. It is a characteristic of this research paradigm that interpretation will continue with each reading of the thesis and in order to facilitate this a large amount of data has been made available to the reader.

Messages from the research

Although not setting out to produce generaliseable knowledge, the understanding achieved in the research makes it possible to offer some contribution to a number of related issues and make suggestions for future research.

Context of practice - a neglected educational issue

The research was undertaken using CHNs from several locations in two Community Trusts. The students were drawn from one educational establishment and had therefore been exposed to one curriculum. However, several cohorts of students were involved in the research. Although a relatively small sample, the diversity strengthens the possibility of transferring the findings to a wider group of CHNs. Indeed, I would suggest that the potential contribution of the research is wider than Community Health Nurses. The focus of the research has been the impact of *context* for practising and learning to practise nursing. The issues identified may therefore have relevance to a range of professionals practising in the community context - health visitors, community mental health nurses, and social workers. It would be interesting to construct the experiences of such a range of community practitioners using the method developed in this study to further clarify and expand understanding of the impact of community as a context for practice. Another research avenue to pursue would be to construct meaning across a range of care contexts. It would then be possible to reveal commonalities and differences between practice environments. Specific educational opportunities would then be more apparent and learners could be directed to these issues.

Engaging in inter-professional learning has been advocated in nursing and related professions for some time - primarily as a route to enhancing team working. However, there may actually be a more fundamental reason for inter-professional learning which has to date been neglected. Not only do community nurses, General Practitioners, social workers work along side each other, but they share a *context of practice*. This may be a basic tenet of inter-professional education which needs to be developed and this research has highlighted some possible routes.

'Breaking down barriers'

Multi-professional working is a central tenet of current government policy (New NHS, Modern and Dependable 1997). One barrier to joint NHS and Social Services working is seen to revolve around lack of understanding of each others roles and problems (Pitkeathley 1999). Adopting an ontological perspective and specifically the method of practice narrative sharing may provide an effective means of breaking down barriers and increasing understanding.

'Barrier breaking' tools may also be useful to facilitate development of understanding of new roles within nursing, particularly when a philosophical change is inherent e.g. medical/illness models compared to health/public health models. Robotham (1998) highlights one of the challenges to health visiting education is that:

> "inevitably then, under moments of pressure in initial practice, the newly qualified health visitor is at risk of being unable to make the penetrative transfer into health visitor conceptualisation and thus drops back onto a nursing framework." (p216)

The clinical component of health visitor education takes place in a one-to-one student:Community Practice Teacher relationship. This mirrors the teaching/learning relationship encountered in this research study. I would therefore suggest that practice narrative sharing may be a teaching/learning tool which may enhance explication of care philosophy and thereby facilitate more effective penetration into the practice world of health visiting.

Teaching nursing

In the introduction to this research I raised the issue of the practice of recruiting nurse teachers from a clinical background in community nursing to meet the need for enhanced recognition of nursing in the community in the pre-registration curriculum. The value of clinical background has been highlighted in this research and provides weight to the concept of 'nurse teacher'. The distinction between knowing-in-action and teaching nursing is crucial. CHNs experiences of limitations on being explicit are perhaps an indication that 'knowing-in-action' (Schon 1987) does not mean that knowledge can be accessed at a verbal level by the practitioner or that it can be effectively communicated to the learner. There is a difference between knowing something and practising it, and knowing something and teaching it. This is an important issue for nurse education and something which we may at times be in danger of overlooking with the demise of the clinical teacher and consequent rising expectations of practice mentors/supervisors.

Nurse education has recently moved out of the NHS and into Higher Education. On a purely geographical dimension there is a division in the components of the education process. The role of the '*nurse teacher'* - a teacher who is a nurse and not merely a teacher of nurses - therefore requires careful consideration and development. An important aspect of the *nurse teacher's* role appears to revolve around being an 'insider' educator, that is having the knowing-in- action, but also the ability and function to facilitate its exposure and communication to the learner. Assisting the learner to develop an appropriate heuristic device to understand practice would be in keeping with the post-technocratic model of nurse education. The NHS Executive (Newton 1999) is reported to believe that "nurse teaching needed to be strengthened". One potential response under consideration is the development of lecturer-practitioner and practitioner-lecturer posts. Part of the rationale for this move may be a perceived bridging of the two locations of nurse education provision. However, the experiences described in this research should guard against the assumption that practice expertise necessarily leads to effective learner education and suggest careful consideration of the components of these developing roles. This is a development in the field of nurse education which warrants further debate particularly around the issue of whether more effective education rests on role change as opposed to developing our reconceptualisation of practice knowledge.

At the time of the inception of 'Project 2000' many institutions were developing curricula that recognised changing conceptions of knowledge and the higher value being placed on practice knowledge. Hendricks-Thomas and Patterson (1995)

expressed concerns that despite this rhetorical change:

> "If you always do what you've always done, you'll always get what you've already got." (p594)

The methodology used in this research, together with the suggestions for approaching education provide strategies to ensure that curricula are current, relevant, relate to and prepare for practice.

The focus of nurse education

Recent changes (UKCC 1986) in pre-registration education were a guiding force in the evolution of this research. The 'Project 2000' initiative is currently under review by the UKCC Commission for Education. One of the impending recommendations is reported to be:

> "...more practice-focused training with more clinical support for students." (Waters 1999)

In many ways this endorses the outcome of this research. However, until these comments receive further clarification I will only proffer a cautious welcome to this news. There is a danger that an increased practice focus could develop into an increased focus on technical skills used in practice. This research and that reported by Hallett (1995) have identified that developing the learning agenda beyond focusing on skills can be difficult. However, unless this is achieved, the full potential for learning all that practising nursing in the community context has to offer may not be experienced.

A recent report commissioned by the UKCC Education Commission *Healthcare Futures 2010* (Warner et al 1998) has identified three "drivers for change" for the health care workforce:

> "...the flexibility of the work context in general; the blurring of boundaries across health professions; and the informal care dimension." (p20)

A pre-requisite to 'role blurring' is that individual professions understand their role and contribution to care. This research goes some way to achieving this in relation to nursing in the community context. All three 'drivers' were present in the constructed meaning of practice of the research participants - finding the practice agenda, negotiating role parameters, sharing care with patients and informal carers, flexibility in responding to a wide range of patient need and care situations. It is therefore very timely to share the experience of practising in the community context with a wider health and social care audience as these experiences appear to have much to offer the health care challenges of the future. The experiences revealed in the research also identify some possible additions to the nurse education curriculum; flexibility, negotiation, uncertainty, power sharing.

Learning and teaching in the practice setting

This research also makes a contribution to the generic issue of learning in and from practice. This is extremely opportune in view of Bines and Watsons' (1992:21) comments that "the practicuum remains the least developed element of most courses." Further research which focuses on sharing meaning construction as a learning/teaching tool is required to develop this as an educational strategy,

although this study would suggest that there is considerable potential. This could be a complement to the already well developed reflection and critical incident approaches used in the uncovering of the epistemology of practice.

There is a fundamental difference between critical incident reflections and practice narrative sharing based on hermeneutical phenomenology. Rich and Parker (1995) identify the purpose of reflection is to:

> "Uncover knowledge used in a specific situation and speculate how the situation might have been handled differently using other knowledge." (p105)

The purpose of practice narrative sharing differs in that it is not focused on problems, but in 'everyday', 'usual' practice experiences which exposes a different layer of the epistemology of practice, a layer which may be much more transparent than that generated through critical incident reflection.

The research may also add to Schon's (1987) work on 'coaching' as a education strategy - allowing the 'coach' or teacher new ways of sharing the meaning of practice with the student. This may be particularly useful in one-to-one student teacher relationships as occur in the community setting.

Levels of practice

A crucial aspect of education is assessment of competency and understanding. In nursing the assessment of competency for safe practice is crucial. Current assessment strategies address technical competency, communication, management skills - all rather overt behaviours. What is lacking is an assessment of the meaning

development which students engage in during the education process. The potential is highlighted by Eisner's (1991) reference to Vladimir Nabokov:

> "Reality is a infinite succession of steps <and> levels of perception. A lily is more real to a naturalist than it is to the ordinary person. But it is still more real to the botanist. And yet another stage of reality is reached with that botanist who is a specialist in lilies." (p63)

Narrative and meaning construction may offer a strategy to access complementary dimensions of assessment which have relevance to initial education programmes and to identifying qualitative distinctions in the practice of first level, specialist and advanced practitioners. These are some of the distinctions currently being debated in the UKCC 1998 consultation document *A Higher level of Practice* focused on clarifying and recognising a higher level of practice in the post-registration framework.

The discussion in Chapter 2 about patterns of knowledge made reference to Jacobs-Kramer and Chinns' (1988) work which supported a search for dynamic meaning rather than structural truth. This research has endorsed the view that nursing can be experienced in different ways. Senior students and CHNs live in different practice worlds. In relation to skill mix and the community nursing teams of the future, this research offers some insight into what may be lost or gained from different skill or level mix formulations.

One direction for future research would be to move on from exploring making sense of practice to tracing the development of the sense making process. It may

then be possible to identify means of facilitating the process. This could also shed some light on whether 'maturity', a characteristic highly valued in community practice by the CHNs in this research, is a matter of osmosis of life events or something that can be addressed and developed in the educational arena.

Health care policy agenda

The detail revealed in this research in relation to 'nurse/patient power balance' and 'participation' is extremely timely in that it supports similar notions coming into government policy agenda:

> "Within the NHS public participation in health and health services decision-making is on the agenda in a way unprecedented since its establishment 50 years ago." (NHSE 1998:1)

It is acknowledged that this demands a philosophical shift for many of the professionals involved. In particular the potential fear of "loss of power and control" is highlighted. The practice experience of community nurses appears to have much to offer this new agenda. CHNs already try to practise to a balanced nurse/patient power relationship and struggle with the uncertainty, risk and sense of powerlessness which can result. To date, the context in which they practise, rather than government policy, has been the key determinant in directing them to develop this partnership approach. Whatever the driving force, their experience of working to this philosophy needs to be shared with other professionals who are about to embark on this road.

Conclusion

Overall, the research process has been a journey which required considerable navigation. The discussion presented in this thesis is therefore as much about how to chart a course as it is about describing the destination. The destination is the community as a context in which to practice and learn to practice nursing. Phenomenology aims to bring "into nearness that which tends to be obscure" (van Manen 1990:32).

During the observation phase of the research one CHN said:

> "When I thought about coming onto the community I looked at the job description and I thought that's all I'm doing now as a ward sister, all I have to do is drive a car around as well. Then, once I started to know the job I realised there was a hidden job description." [chn10]

As a consequence of this research 'hidden' aspects of nursing in the community have been revealed and the impact of this context can now be more fully appreciated.

APPENDICES

APPENDIX 1

Information presented verbally and in written format to students when seeking their participation

I'm currently involved in a research project and would be very grateful if some of you would agree to assist me with it.

I'm very interested to know more about what community nursing means to senior students when they have completed or are near completion of the community module of the branch programme.

What I'm asking is for volunteers to meet with me in a group to just generally discuss your experiences.

I'm not evaluating you or testing you on what you know, I just want to get some insight into what community nursing means for you.

A group discussion would be useful to allow us to share a range a experiences. So that I can participate in the discussion and listen properly to what you are saying I would preferably like to tape the discussion rather than make notes as we go along. Only I would listen to the tape later for purposes of noting down the issues we discuss. We would meet towards the end of the module and I anticipate that the discussion could last up to an hour - depending on how talkative you are !

If you have any questions or want to clarify anything - please ask me now - or at any time during the process.

If you are willing to assist me please sign the attached sheet. If you do not wish to participate - that's fine, it is an entirely free choice.

Thank you

IF YOU ARE WILLING TO PARTICIPATE IN A GROUP DISCUSSION ABOUT YOUR EXPERIENCES DURING THE COMMUNITY MODULE - PLEASE SIGN BELOW

THANK YOU VERY MUCH FOR YOUR ASSISTANCE

APPENDIX 2

Explanatory letter and consent form sent to CHNs

Address,
Telephone

Dear .....

I am currently employed as a senior lecturer at ..... and I am also a part-time Ph.D. research student.

.....(Director or Research Nurse) has given me permission to carry out some of the research in ..... and I am writing to introduce the project to you.

Community nursing is currently receiving a great deal of attention and the skills and expertise of community nurses are being given greater recognition. A very significant issue is the introduction of Project 2000 education which has provided us with the potential for a first level nurse who has been prepared to function in hospital and community settings.

My research is exploring student and qualified nurses perceptions and experiences of nursing in the community. I would be very interested to learn about your views and experience and would like to arrange to discuss these with you. I would ideally like to organize small group discussions as I consider it's useful and interesting to share ideas with a group of people. However, I would also be happy to arrange to speak to some people on an individual basis.

I am aware of the many demands on you time, but hope you will be able to participate in the research. I have therefore attached a very brief questionnaire and would be grateful if you would return it to me in the enclosed envelope.

If you have any questions please donot hesitate to contact me at the above address.

Yours sincerely,

Susan Carr

THANK YOU VERY MUCH FOR AGREEING TO CONSIDER PARTICIPATING IN THIS RESEARCH. I WOULD BE GRATEFUL IF YOU WOULD ANSWER THE FOLLOWING QUESTIONS.

NAME _____
BASE _____
PHONE NO. _____

CASELOAD DETAILS:
Do you a have a 'general' caseload or do you specialize in a certain type of patient/client, type of care ?

_____
_____
_____

WHICH DAY/S OF THE WEEK & TIMES WOULD BE MOST CONVENIENT FOR YOU TO PARTICIPATE IN A GROUP DISCUSSION ?

_____
_____
_____
_____

HAVE YOU ACTED AS MENTOR / WORKED WITH STUDENTS ON THE ADULT BRANCH COMMUNITY PLACEMENT ? YES / NO

HOW LONG HAVE YOU PRACTICED AS A COMMUNITY NURSE ?

WOULD YOU BE INTERESTED TO PARTICIPATE IN :

◊ *GROUP DISCUSSION YES / NO and /or*

◊ *INDIVIDUAL DISCUSSIONS YES / NO and /or*

◊ *FOR ME TO ACCOMPANY YOU ON SOME VISITS (THIS WILL THE SECOND PHASE OF THE RESEARCH) YES / NO*

THANK YOU FOR THE INFORMATION, I LOOK FORWARD TO CONTACTING YOU .

APPENDIX 3

Collated CHN responses (for one locality) identifying convenient times to hold focus groups

CHN	Mon am	Mon pm	Tues am	Tues pm	Wed am	Wed pm	Thur am	Thur pm	Fri am	Fri pm
1					*	*				
2						*		*		
3			*					*	*	
4			*				*			
5						*				
6		*								
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11				*	*					
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All the responses showed a similar level of diversity

APPENDIX 4

Letter sent to CHNs prior to focus group

Address,
Telephone

Dear.....

Thank you for responding to my previous letter and identifying convenient times for a group discussion.

I'd like to confirm a meeting on:

- date
- time (I have booked the room for 1 hour)
- venue

As I explained in my previous letter, my research is exploring student and qualified nurses perceptions and experiences of nursing in the community. I am interested to get an insight into what community nursing means for you. Everyone will have had slightly different experiences so I think a group discussion where we can share experiences will be really useful and interesting. There will be no more than 7 nurses at the meeting - all nurses from your locality, so you will probably know each other. There will not be any students at the meeting.

So that I can participate in the discussion and listen to what you are saying I would preferably like to tape the discussion rather than make notes as we go along. Only I would listen to the tapes later for the purposes of noting down the issues we discuss.

If you can't make the meeting please let me know at the above address.

I look forward to seeing you on the [date] and thanks for your interest and cooperation to date.

Susan Carr

APPENDIX 5

Practice narrative guidelines

RECORDING GUIDELINES

THE PURPOSE OF THIS EXERCISE IS TO RECORDS THE DETAILS OF EVERYDAY EXAMPLES OF NURSING PRACTICE .
BY DETAILS I MEAN :

⇒ THE PURPOSE OF THE VISIT/ ENCOUNTER

⇒ WHAT HAPPENED - RECOUNT THE COURSE OF EVENTS AS THOUGH YOU WERE DESCRIBING IT TO A COLLEAGUE - GIVING THEM A RUNNING COMMENTARY ABOUT HOW YOU WERE MAKING SENSE OF / OR UNDERSTANDING THE VISIT.

THERE ARE NO RIGHT OR WRONG WAY TO COMPLETE THIS EXERCISE AND THERE IS CERTAINLY NO ELEMENT OF EVALUATION OF PRACTICE INTENDED. I'M INTERESTED TO LEARN <u>YOUR UNDERSTANDING AND INTERPRETATION</u> OF YOUR EXPERIENCES.

THE TAPE RECORDER IS IN YOUR CONTROL - PLEASE LISTEN TO THE RECORDINGS IF YOU WISH - YOU ARE FREE TO WIPE ANY CLEAN IF YOU DECIDE YOU DO NOT WISH TO SHARE THEM WITH ME.

IF YOU USE A PATIENTS OR COLLEAGUES NAME OR ANY OTHER IDENTIFYING STATEMENTS - I WILL CHANGE THEM WHEN I TRANSCRIBE THE TAPES TO ENSURE CONFIDENTIALITY AND ANONYMITY. I WILL BE THE ONLY PERSON TO LISTEN TO THE TAPES AND YOU WILL BE IDENTIFIED ON THE TRANSCRIPT BY AN IDENTIFYING NUMBER KNOWN ONLY TO ME. WHEN THE TRANSCRIPTS ARE SHARED WITH OTHER CHNS OR STUDENTS AT A LATER DATE - ALL PARTICIPANTS WILL BE ANONYMOUS.

THANKS YOU FOR YOUR ASSISTANCE

APPENDIX 6

Practice narrative discussion guidelines

As you know, mentor and student pairs have been recording their descriptions of mutual visits. The purpose of this exercise was to attempt to identify :

1. issues which may clarify the experience of nursing in the community context
2. where students and mentors agree/disagree, notice similar/different things

What I would like you to do today is to become involved in the analysis process - i.e. exploring the transcripts students and mentors have produced.

There are a number of transcripts, each set contains the student and mentor description of the same visit.

What I would like you to do today is:

⇒ *read the transcripts*

⇒ *write in the margins any comments/reactions which you experience*

⇒ *I'd then like us to share our comments in a discussion. If you have no objection, I will tape our discussion so that I may participate without having to write notes at the same time (I will be the only person to listen to the tapes)*

APPENDIX 7

Summary of research strategies

FOCUS GROUPS

4 student groups

4 CHN groups

OBSERVATION / CONCURRENT INTERVIEWING

5 sessions

PRACTICE NARRATIVES RECORDINGS

7 CHN/Student pairs

NARRATIVE DISCUSSION GROUPS

4 CHN groups

APPENDIX 8

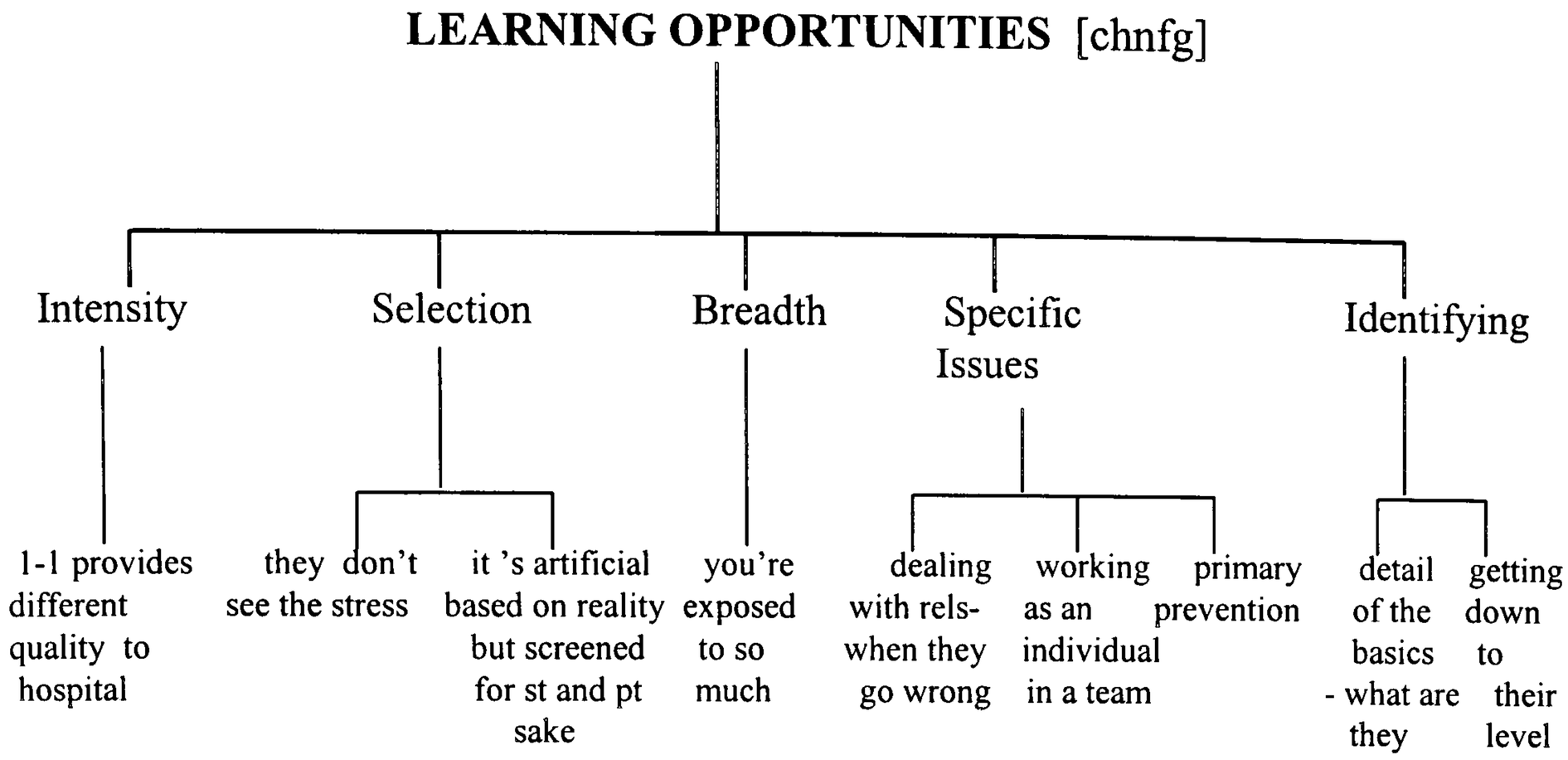
THEME TREEES

Learning Opportunites

Communication

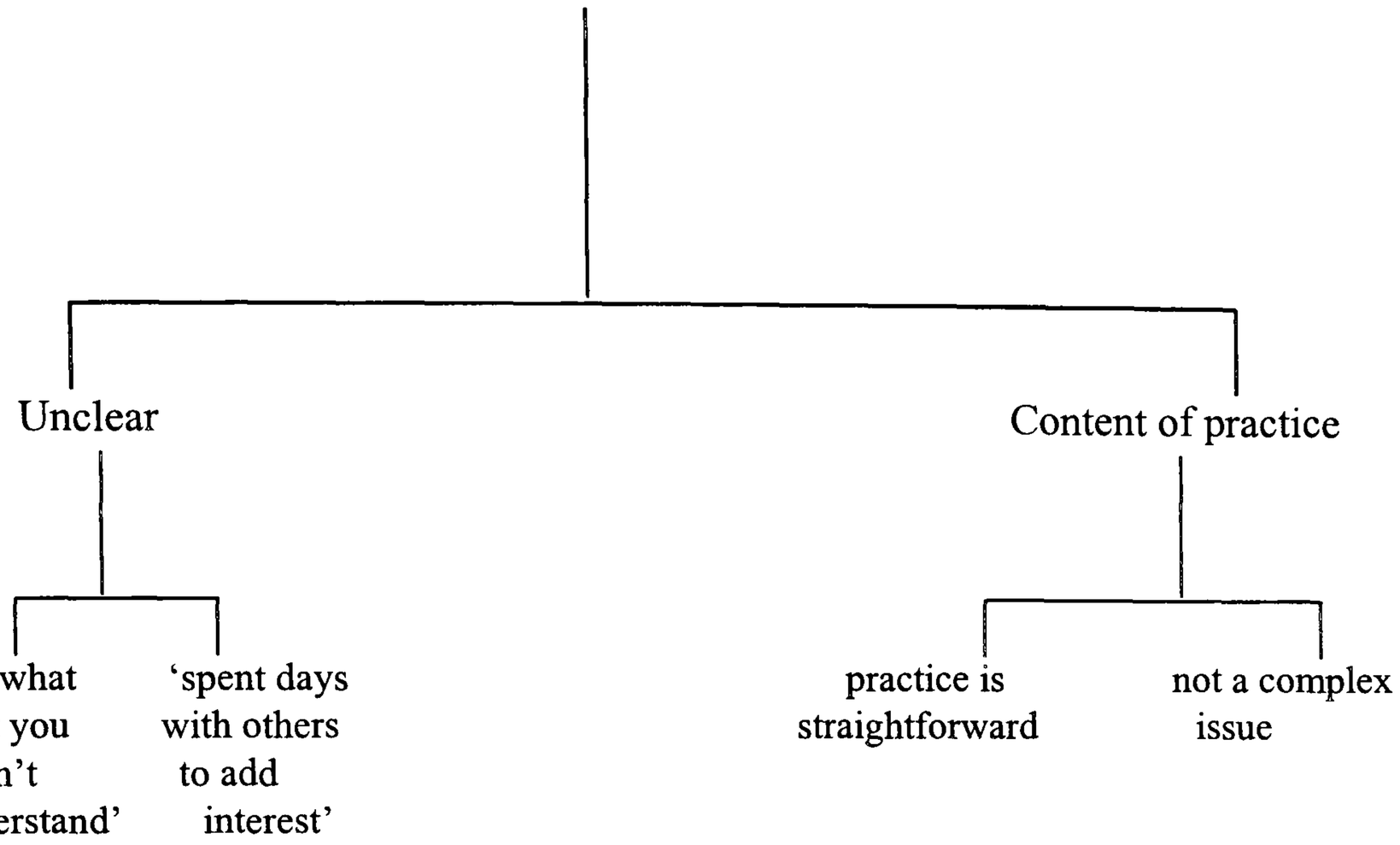
Decision Making

By Yourself / Responsibility



* new/unique aspects of learning are available in the community
* the community setting places some restrictions on learning - this perhaps provides unique circumstances which does not work with the model of learning transferred from hospital - also has research implications
* teaching /learning relationship is different to hospital
* some aspects of practice are selected out - does this often happen in hospital ?

LEARNING OPPORTUNITIES [stfg]

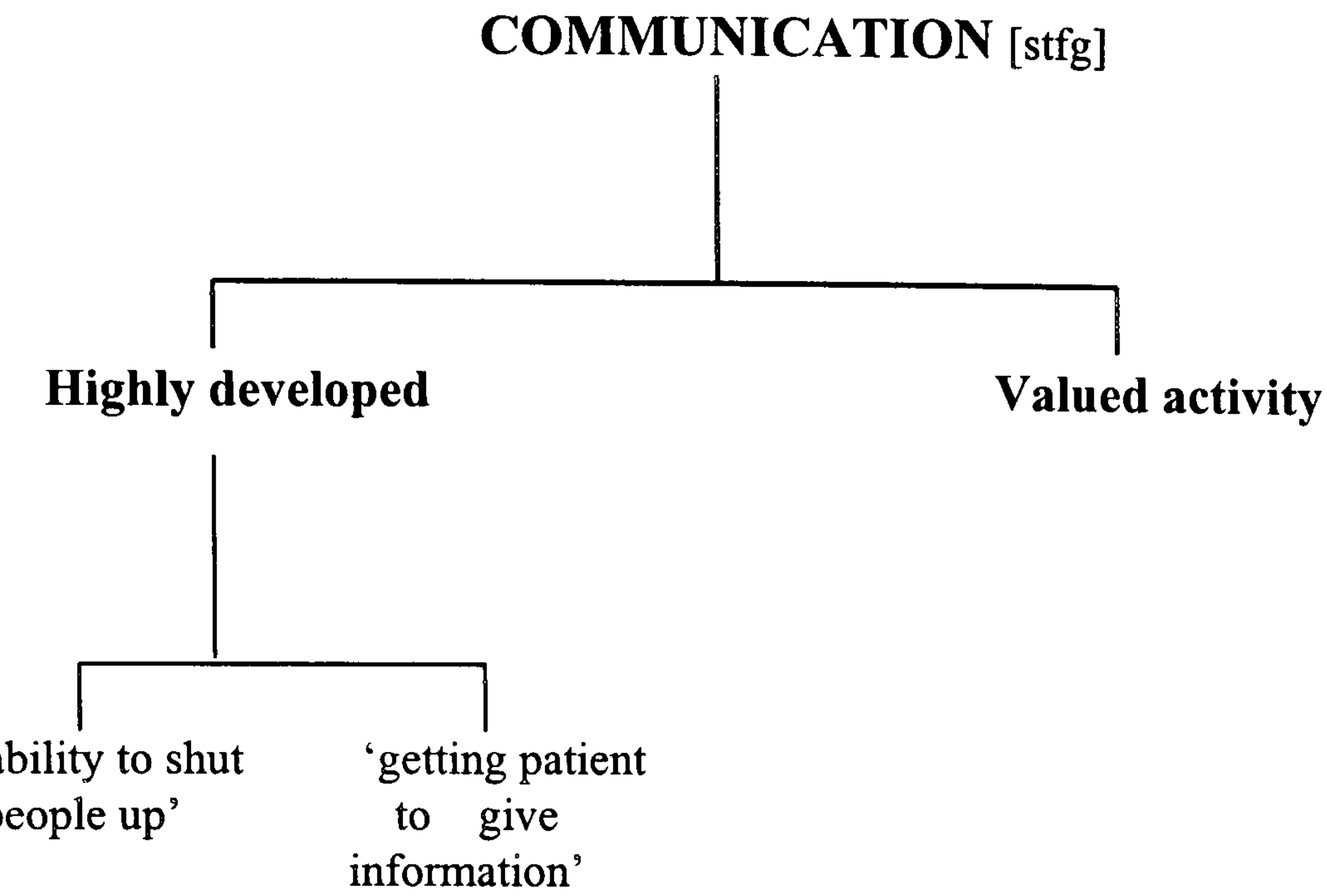


* there is a lack of clarity as to the clinical curriculum for the student
* the content of practice is obvious - suggest a closed learning agenda

COMMUNICATION [chnfg]

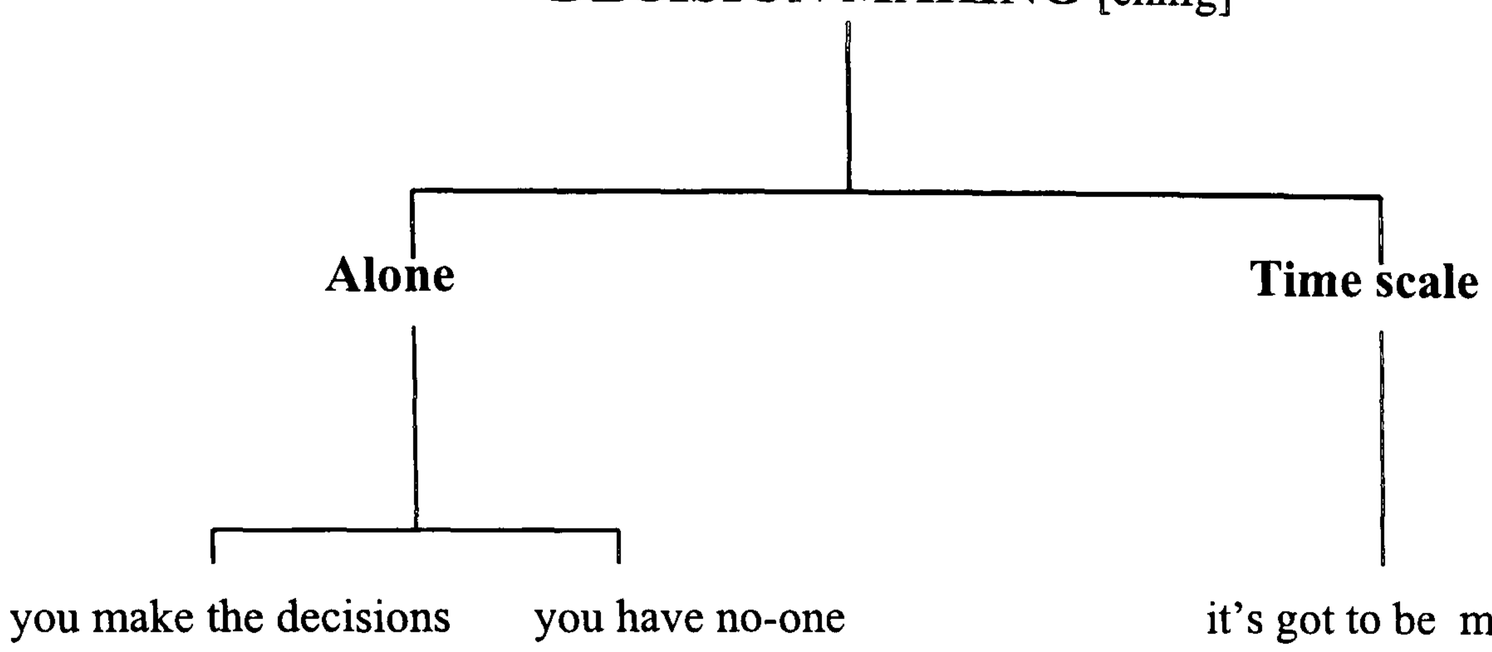
High level skills		**Realism**			**Power balance**
st previously unexposed - excluded from this level in hospital -it would be senior staff	getting balance right - between cold & over friendly - you're not visiting a friend, but it is someone's home	seeing cues to underlying issues	need to learn people lie to you	it's rarely a one-off contact - people are more frank	we see people as they are	you can't pull rank over the pt in their own home

* communication in hospital and community are different - style & content ?
* higher level of realism in the community ? - ?? suggesting opportunity to hide behind 'role' to assist communication is less available
* suggesting community allows student to enter a level of practice usually closed to them in hospital setting - students don't highlight this

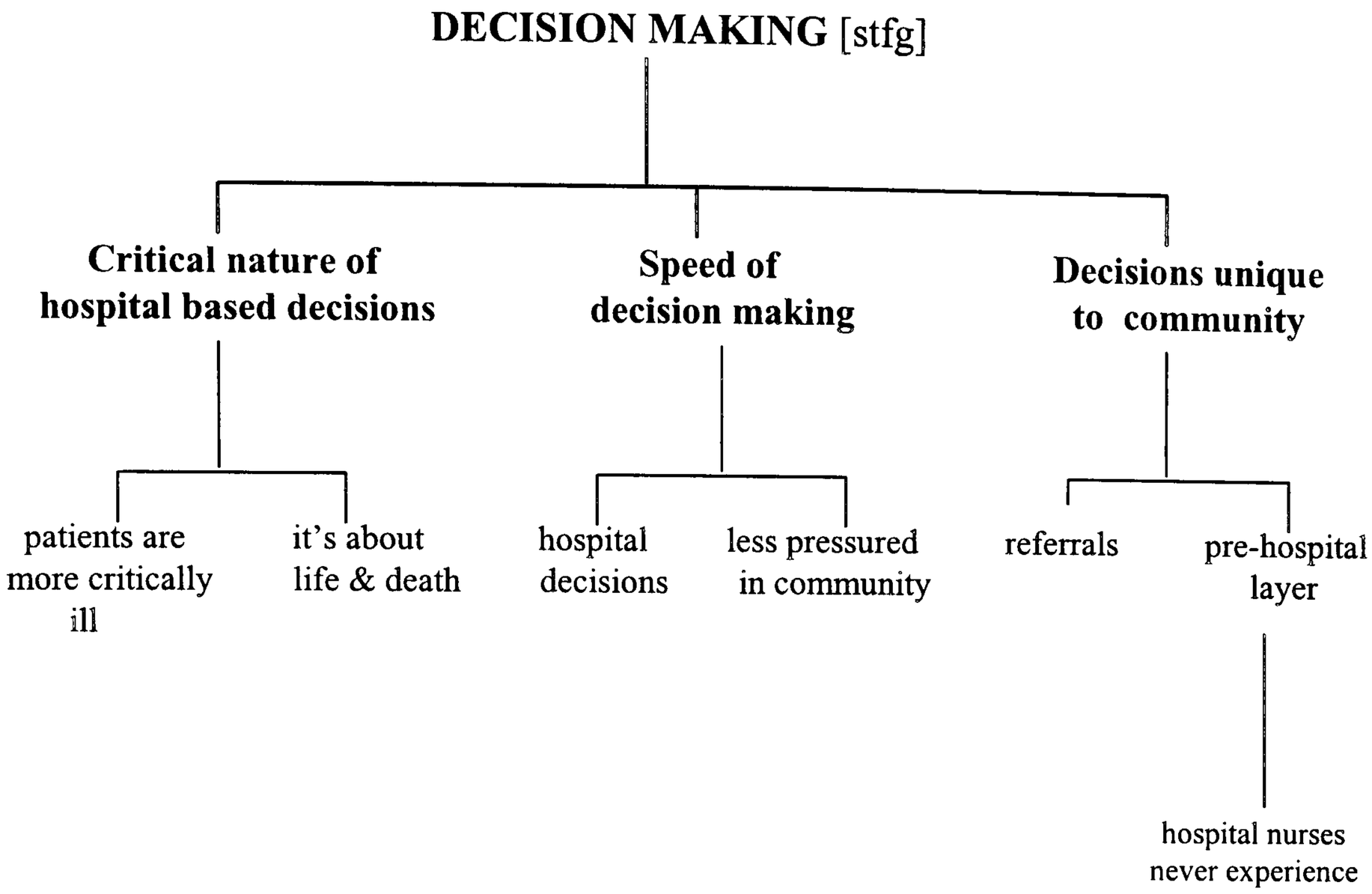


* communication is seen as valued aspect of nursing practice - why ?/ - what is the agenda fro practice that requires such communication - does this hint at a level of complexity???

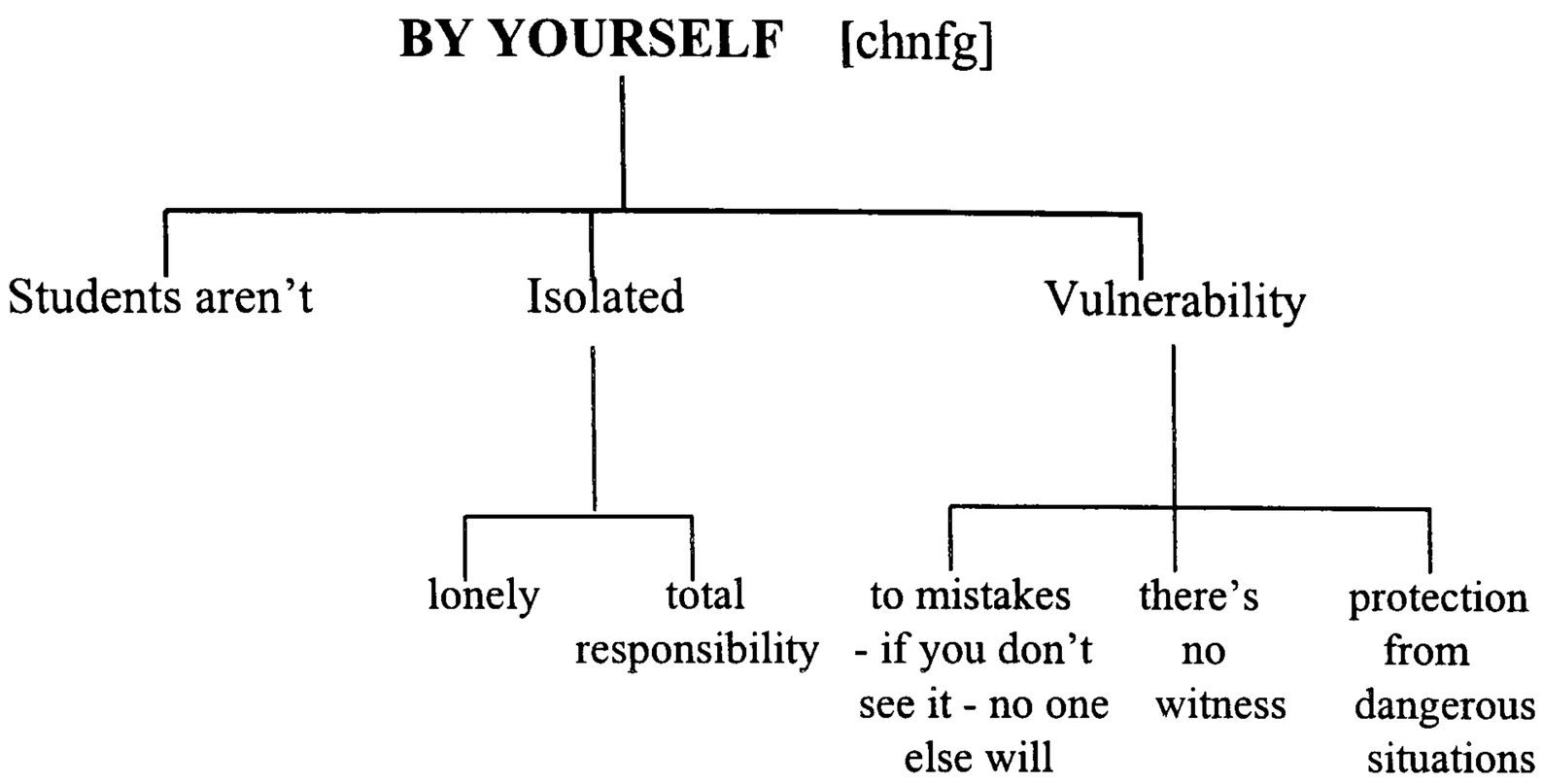
DECISION MAKING [chnfg]



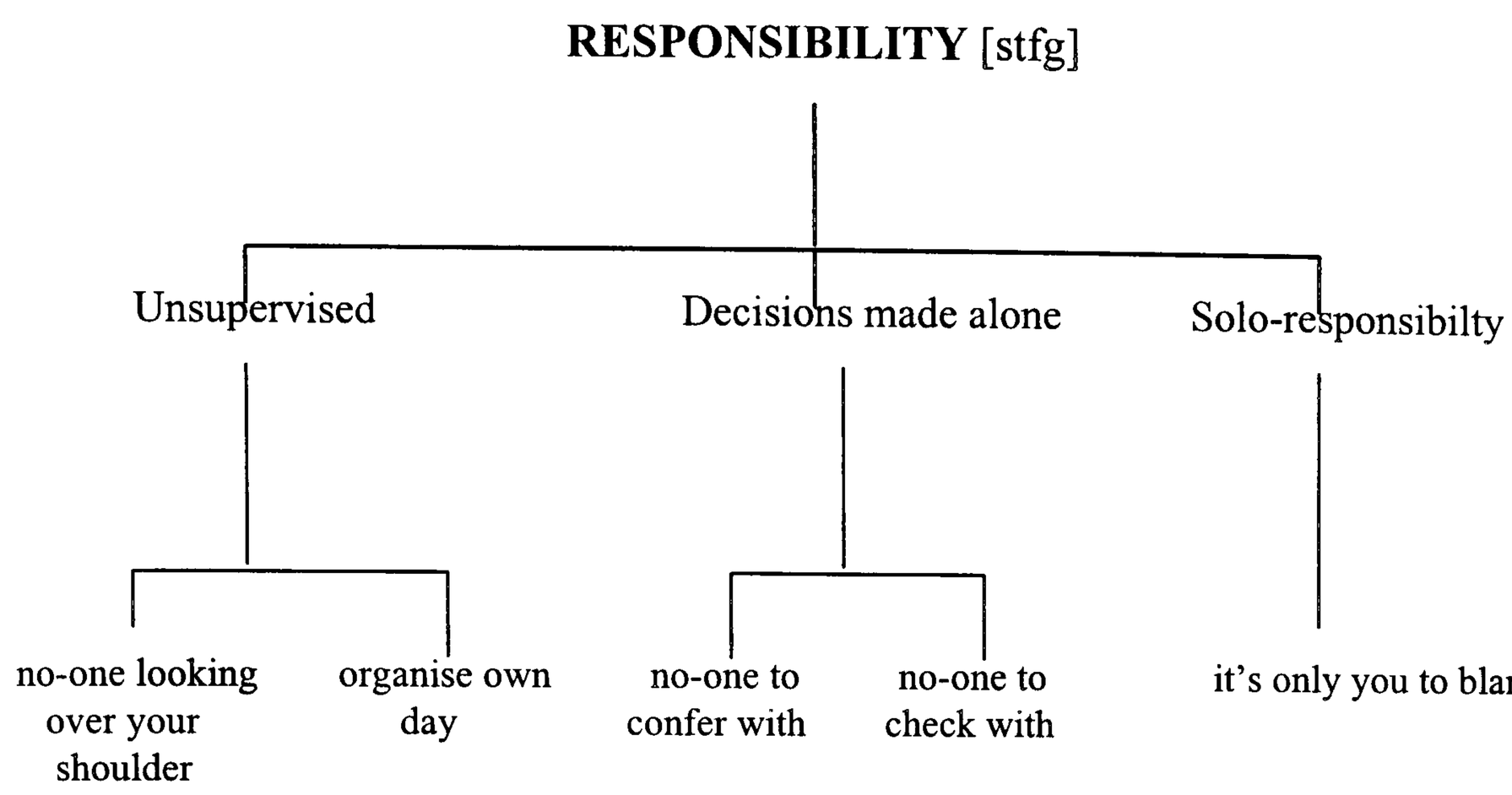
* there is a psychological/ affective dimension to decision making in addition to a knowledge base dimension
* decisions are made in eh full exposure of the client/carers etc. - this also happens with GPs



* decisions are seen to be of a less serious nature than in hospital - but not all hospital decisions are based on life/death dilemma
* time-scale of decisions appear to have a value judgement - again referring to critical care situation when decisions are urgent . However, no mention is made of the complexity factor, just speed e.g. responding to heart monitor bleep in ITU may be interpreted as fairly simple, although essentially a rapid decision - response however may be to simply implement pre-determined technical procedure
* community does offer the opportunity to make new types of decisions - ie when to refer a patient for alternative care (this must go on in hospital as well) and pre-hospital referral ?? are students hinting at categorisation being made without medical legitimisation ?? If new and different decisions are being made- how does this fit in with 'obvious practice'



* interpretation of being alone must be different for CHN and students - student is imagining prospect - CHNs live it



* practice interpreted as being unsupervised - consequences of trust and responsibility hinted at in terms of decision making
* decision are made without being able to confer / check - with fear of 'getting it wrong'
* suggestoins that CHNs were 'lucky' not to have someone 'looking over shoulder' Flexible working arrangements - ie call on patients when they see fit, have breaks when they 'feel' like it - no mention of the complexity of self organisation, caseload management, identifying, interpreting, prioritising need and time

APPENDIX 9

Paper presented at:
'Making a difference: 2nd International Conference on Community Health Nursing Research' Herriot Watt University, Edinburgh, Scotland August 1997

'Exploration of the constructed meaning of nursing in the community'

Research aims:
To enhance the way in which practicing nursing in a community context is understood

Background:
As a consequence of recent government policy the focus of care is moving from the traditional setting to the community setting. The traditional frame of reference for initial nurse education, hospital nursing, is therefore being challenged. This changing orientation has focused attention on the question 'what does it mean to nurse in the community context?' As a consequence of recent developments in nurse education (principally Project 2000) the opportunity to make comparisons between nurses educated to practice in the community at both first level and post-registration level has only recently become possible. This provides unique circumstances which affords a 'window of opportunity' to better understand professional practice.

Design:
The phenomenon of nursing in the community context is being explored by juxtaposing the reality construction of specialist practitioners (community health nurses) and Project 2000 adult branch students. The research is guided by an interpretive framework drawing on the research perspectives reported by a number of researchers, e.g. Benner (1984) and MacLeod (1990). The community setting as a research environment provides particular challenges. Research in a similar vein has principally been focused on the institutional context. Focus groups with students and community health nurses were the main method of data collection in phase one of the research.

Discussion:

The research has conformed with the findings of other research in this field in that practitioners experience some difficulty in accessing and describing constructed meaning of practice. Participants, particularly CHNs, claimed that the world of community nursing could be understood or perceived at differing levels of complexity. They were able to make broad distinctions between themselves and students which gave some indication of the issues involved in their construction of the meaning of practice. Routineness, responsiveness and coping with the unexpected were recurrent themes. There area number of potential implications of the research. It aims to contribute to understanding of the constructs of community nursing practice. This exposition and articulation may then facilitate clarification of educational need.

GLOSSARY

COMMUNITY HEALTH NURSE

A term used to refer to post-registration educated nurses working in the community setting (these posts usually receive a G/H grading). This research only refers to those nurses who act as mentors/provide significant experience for adult branch Project 2000 students.

FIRST LEVEL NURSE

This term denotes a nurse who has been educated to registration level. On completion of a Project 2000 course a student is awarded a Diploma in Higher Education and Registered Nurse qualification, this allows them to be admitted to the UKCC Register for Nursing.

The first level nurse is usually employed as a staff nurse grade D/E.

GRADING STRUCTURE

In the late 1980s all nursing posts were graded along the continuum D-I.

PROJECT 2000

Project 2000 represents a dramatic rethink in nurse education. Previously the vast majority of nurses have been educated/trained to prepare them to function in a hospital setting, although they would have had short observational placements in the community settings. The proportion of time now spent on community placement has increased dramatically. The purpose of these placements is not observational i.e. to get an insight into another facet of health care, but to educate and prepare students to function as nurses in that setting and they are assessed on their ability to do so.

Prior to Project 2000 students were part of the service team i.e. they were included in calculation of staffing levels for clinical areas. Project 2000 changed student nurse status to supernumerary for a substantial proportion of their course. This was a change

on emphasis from learning by doing to also learning by observing and working alone side others for the purpose of learning without the commitment of being counted as a member of the ward staff.

SISTER GRADE

In the hospital setting, the senior nurse on the ward holds the post of sister (usually awarded F/G grade). There is usually only one sister, but a number of staff nurses and support workers on each ward. The sister may have undertaken have undertaken some post-registration education, although this is not obligatory.

In the community setting, District Nursing Sisters and Health Visitors hold the equivalent type of post as a ward sister (they are graded G/H). In order to hold this type of post the nurse must have undertaken a 12 month post-registration course.

SPECIALIST PRACTITIONER

This is the term used by the UKCC (1994) to denote a practitioner who is able to exercise higher levels of judgment and discretion in the clinical area. The level of study for this grading in the future will be at no less than degree standard.

STAFF NURSE

This is the type of nursing post held by most registered nurses in a hospital setting (generally graded D/E). The pre-registration course (Project 2000) educates students to fulfill this role. One of the major changes in nurse education as a consequence of Project 2000 was that pre-registration education would educate students to fulfill a staff nurse role in hospital and community setting.

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